



Returning Home, Back to Community from Custodial Care

Learnings from the first year pilot project evaluation of three sites around Australia

August 2014

Prepared by the Evaluation Team, Muru Marri, SPHCM, UNSW

Core Acknowledgement

In the spirit of respect, we acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia.

This country is the only place in the world where Australia's First Peoples belong, and there is no place in Australia where this is not true.

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Muru Marri, School of Public Health and Community Medicine, UNSW

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Authors

Melissa Haswell, Megan Williams, Ilse Blignault, Marcia Grand Ortega, Lisa Jackson Pulver

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Contributions and Acknowledgements

In the spirit of respect, we acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia.

We acknowledge the support and contributions of our colleagues at Muru Marri, the team who developed the three Returning Home Back to Community from Custodial Care projects for their generosity of time and insight and Lesley Russell (Australian Primary Health Care Institute, ANU) for giving us this opportunity.





Contributions and Acknowledgements

People

Evaluation design, development and evaluation

Ilse Blignault, Marcia Grand Ortega, Melissa Haswell, Megan Williams, Lisa Jackson Pulver

Literature review

Megan Williams

Programs review

Marcia Grand Ortega, Megan Williams

Cross-case analysis and metasynthesis

Melissa Haswell, Megan Williams

Case study programs and teams (in alphabetical order, evaluation team underlined)

- **Geraldton:** Ilse Blignault, Sonya Crane, Marcia Grand Ortega, Jacki Ward
- **Townsville:** Kimina Andersen, Joanne Bourne, Bianca Brackenridge, Carl Grant, Tonya Grant, Melissa Haswell
- **Western Sydney:** Ilse Blignault, Dea Delaney Thiele, Marcia Grand Ortega, Melissa Haswell, Sheila Hure, Lisa Jackson Pulver, Jamie Matthews, Leanne Schuster, Megan Williams

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Cover artwork

The drawing on the cover of this report was done by Lisa Jackson Pulver. The story is all about the journey we undertake, each in our organisations and that which we take as a collective. We are never alone on this journey, and every action has an effect on others.



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Abstract

The *Returning Home Back to Community from Custodial Care* pilot project was designed to build a better understanding of the most appropriate model of community care to support improved health outcomes for Aboriginal and Torres Strait Islander women leaving custody. Funding was provided by the Commonwealth Department of Health to three organisations to plan and trial care pathways that assist women with coordinated and integrated support structures to facilitate re-engagement with service providers following release. These were the Aboriginal Medical Service in Western Sydney, the Townsville-Mackay Medicare Local in Townsville and the Goldfields-Midwest Medicare Local in Geraldton, Western Australia. All teams agreed at an initial meeting that in order to be sustainable, assistance needed to strengthen women's own capacity, resilience and support networks to create circumstances that provide meaning and direction to their future.

This report details the findings of the pilot program evaluation, which integrates learnings from four outputs (literature review and three case studies) carried out from November 2013 to August 2014. . The key findings from a cross-case analysis are expressed as barriers and enablers at structural, organizational and program levels. The report culminates with a synthesis of these findings applied to a new framework *Ngaa-bi-nya*, creating a guide to inform and evaluate programs developing post-custodial transition arrangements in other places .

All three sites experienced organizational and program challenges that resulted from an overriding structural barrier of inadequate communication, acceptance, commitment, shared goals and accountability and coordination at the structural levels between the Commonwealth Department of Health, State Departments of Corrections and Health and other bodies providing post-release services. At one site, however, many of these challenges were overcome, enabling rich, multi-faceted group and individual care pathways to engage and assist 126 women.

At organizational level, an overarching enabler was engagement from the very beginning of the project with skilled and experienced Aboriginal managers who followed cultural protocols of engagement with community Elders and leaders and existing programs from the beginning. These managers were skilled at identifying the required criteria for program staff and in nurturing their development and confidence in delivering on the multiple and complex challenges required to achieve success in establishing feasible pathways for delivery of care across the vast array of services involved in providing care to meet the women's needs. These include health, housing, social services including for reunification with their children and families and employment.

At program level, effectiveness in assisting women to meet their immediate and longer term needs for health and wellbeing was enabled by coordinated care planning, the creation of safe spaces to deal with emotional burdens, confidence- and voice-building experiences with services, and access to opportunities, such as group healing and leadership programs. These assisted women to recognize their own strengths, agency, connections and potential to realise new directions.



Executive Summary

The *Returning Home Back to Community from Custodial Care* (RHCCC) pilot project was designed to build an improved understanding of the most appropriate model of care that Aboriginal and Torres Strait Islander women can expect from community-based service providers who are focused on improving their health outcomes, especially those related to mental health. In addition, the evaluation team was asked to identify the best approach in primary health care service delivery to enable improved transition arrangements for this client group; and learnings that can lead to developing a model of care arrangement for the wider cohort of post-custodial care clients.

In order to support and add value to this important project, the Muru Marri evaluation team undertook a series of related activities. A literature and program review examined existing evidence. Communication and learning was supported across all three sites stimulated through an initial face-to-face meeting, progress report teleconferences and two information-sharing Newsletters. In each setting, the evaluation team in some cases supported, and in all cases documented, the project's efforts through case studies using data collected through in depth interviews with teams and key stakeholders as relevant. A cross case analysis of the case studies highlighted diversities across settings and experience, identifying key barriers and enablers at structural and organizational levels, and examining the rich array of program learnings and activities developed by the teams. The final activity, articulated in this report, was a metasyntesis, utilising an Aboriginal framework, *Ngaa-bi-nya*, to integrate learnings from all the activities to create a culturally-informed evaluation framework capable of assisting program planning, monitoring progress and evaluation program quality, impacts and outcomes.

Key Contextual Issues

One of the first findings from the evaluation was the great diversity of situations, staff and challenges posed across the sites. For example, the Goldfields-Midwest Medicare Local and the Townsville-Mackay Medicare Local RHCCC teams were faced with particularly vast geographical areas ranging from urban to extremely remote communities to which their clients returned following release. The Aboriginal Medical Service Western Sydney team faced the unique challenge of having three correctional centres from which the women were released to their own catchment area in Western Sydney and the Blue Mountains.

Because of these many diversities, each case study stands alone. However, despite the differences, many common learnings emerged. These can be considered universally important, but appropriately addressed through different



ways in different places, highlighting the clear message of “one size doesn’t fit all”. The focus is particularly on the commonly experienced learnings at the structural, organisational and program levels, citing some of the variety of ways they were addressed and/or overcome or impassable within the project tenure.

Key Structural Issues : Embedding the project across sectors

All three sites experienced, to varying degrees, barriers in building relationships and partnerships that resulted from inadequate communication, acceptance, commitment, shared goals and accountability and coordination at the top levels between the Department of Health, Corrections and all relevant Departments providing post-release services. This not only reduces the likelihood of positive post-release outcomes, it proved enormously challenging for this time-limited, pilot project seeking to go beyond usual care. Waiting for clearance to enter the correctional centres was particularly disheartening and interrupted progress enormously at two of the three sites.

Fortunately one site provided an outstanding example of the enormous impact that can be made when the Correctional Centre Director does embrace the program almost from the start and facilitates the achievement of its full potential – with the team of two staff receiving referrals and providing pre- and post-release planning and an array of other supports with 126 women.

Gaps across other post-release services led to further difficulties in achieving comprehensive post-release planning. Safe and appropriate housing was seen to be a particularly difficult challenge and was viewed as a fundamental first step, particularly in the urban setting.

While these service gaps were, with the notable exception of housing, overcome locally by goodwill in local leadership and persistence and determination by the RHCCC teams to varying extents, the need for all parties to start with clear direction and, guidance from Aboriginal people and shared accountability operationalised through Performance Indicators for better outcomes for the women from the top cannot be overstated. Shared accountability through performance indicators to these better outcomes by all parties and formalization of roles and responsibilities will ensure that this becomes an expectation of ongoing routine services, not only during project lifetimes. Otherwise time, resources and energy will be unnecessarily lost and success restricted or even prevented completely due to apparent absence of good will.



Organisational Principles : Preparing the groundwork within organisations

Many organisational challenges were differentially experienced across the three sites and led to the recognition of key principles that promoted and accelerated success if in place, and conversely led to time and energy loss when not in place. These principle enablers, highlighted in the literature as core requirements for sustainable success, now extended with evidence from the case studies, include:

1. Capable and connected senior Aboriginal managers need to be directly and influentially involved in funding processes, proposal development, recruitment criteria and selection, and decision-making from the beginning.
2. Leadership and implementation of programs by Aboriginal and Torres Strait Islander people or by fully accepted non-Indigenous people is essential for ensuring cultural safety and effective care.
3. A diversity of skills, experience and personal qualities mix of the team is needed to address the diversity of challenges faced by women returning home from prison and by programs working in this complex environment.
4. Community engagement from the beginning is crucial for setting in place an optimal support program able to meet the wholistic and cultural needs of the women to equip them on their challenging journeys back to their communities.
5. Formal and informal networks and cultural brokerage skills are crucial.

Program-level Opportunities : Creating an effective model of care

Programs and services for Aboriginal women must be both gender-sensitive and culturally appropriate. Those that operate from a community base and incorporate known critical effectiveness factors for improving social and emotional wellbeing are more likely to be effective in the long-term. At the same time, the underlying issues and upstream social determinants of health must be addressed. The Bindal Leadership Program delivered through the Townsville program focuses on healing and empowerment – aiming to enable women to take greater control over their lives, reducing vulnerability and enhancing resilience and agency.



A wealth of experience and learnings emerged in the following key areas:

1. Identifying Aboriginal values in the overarching principles of care
2. Engaging with women with effective care planning and care coordination at optimum times to commence throughcare support.
3. Creating safe spaces for women to share their emotional burden.
4. Facilitating access to Aboriginal healing and leadership programs inside.
5. Managing eligibility issues and inclusive versus limited access
6. Facilitating group involvement of family members and friends on the outside
7. Promoting confidence and voice in service provider interactions to facilitate positive choice, reduce difficulty in post-release service access and add value.
8. Measuring, acknowledging and celebrating achievements to further cement gains

Recommendations

Finally, in order to achieve greater success in creating programs to assist Aboriginal and Torres Strait Islander women returning home from custodial care in future, we make the following eight recommendations for using these learnings in future policy and practice:

- Funding schemes need to be mindful of the enormous diversity of settings and operate with flexibility and responsiveness to local knowledge and voices in the design and delivery of policy and programs.
- Quality programs in this crucially important and sensitive area should be properly resourced on a continuous basis, avoiding pilot or short term programs with no assurance of continuity.
- Establish a high level alliance across departments to address these challenges, start multi-sector projects at a high level, getting buy in and shared goals and accountabilities across all stakeholders.
- Establish and maintain avenues for shared accountability at all levels and ensure that essential information, e.g. providing dates of discharge and court hearings, are known to supporting stakeholders.
- Adopt a can do, not a can't do attitude, address entrenched can't do attitudes at all levels in the system by formalizing clear roles, responsibilities and expectations with performance monitoring.



- Understand that experienced, skilled and empowered Aboriginal people working on the ground will know what to do and how to do it.
- Value formal and informal networks that Aboriginal and Torres Strait Islander managers and health workers bring, their previous successes and their knowledge of sustainability in decision making.
- Ensure that programs are well supported to implement mechanisms to collect appropriate data on program quality, needs assessment, process, impacts and outcomes and costs to enable demonstration of their value.

Metasynthesis and Evaluation framework

Application of the pilot project findings to an Aboriginal framework, Ngaa-bi-nya, adapted from Stufflebeam (2003), and aligning and modifying an existing set of Critical Success Factors (Haswell et al., 2013), yielded a set of research-informed tools to guide the planning and evaluation of programs, such as the envisioned full implementation of Returning Home Back to Community from Custodial Care. Two existing tools, namely the Critical Effectiveness Factors and Critical Sustainability Factors were shown to be highly applicable to the three case studies. Two additional Critical Factor tools, based on the recommendations above, were developed to ascertain the extent to which enabling structures (Critical Landscape Factors) and appropriate resources (Critical Resource Factors) are available to ensure that future post-release initiatives are likely to reach their full potential.



Introduction

Background

Returning Home, Back to the Community from Custodial Care (henceforth *Returning Home*, *Returning Back to Community* or *Returning Home to Community from Custodial Care*) is a national project funded by the Commonwealth Department of Health. The project aims to develop effective models of care that will enhance the health and wellbeing of Aboriginal and Torres Strait Islander women who are returning to the community from prison. The first year pilot project has been implemented at three sites around the country: Geraldton in Western Australia, Townsville in Queensland and Western Sydney in New South Wales.

Muru Marri, an academic unit of the School of Public Health and Community Medicine at UNSW Australia, was commissioned to undertake an evaluation of the pilot project by conducting a literature review and three case studies to tell the story of its the progression at each location—from initial ideas to developing and implementing care pathways where possible. This report documents the people and processes involved, the challenges encountered, pathways and activities developed and the lessons learned at the three sites, then synthesises these findings with literature to extend the knowledge base for more effective policy and practice.

Returning Home, itself, emerged from the Services and Primary health care needs for Recently released Inmates in Need of Treatment and health management (SPRINT) project, which sought to provide a culturally-specific understanding of how primary health care services can improve health care and social support for Aboriginal people in contact with the criminal justice system and transitioning back into the community. The necessity for a wholistic and integrated case management approach was highlighted. *Returning Home* gave the opportunity for Medicare Locals and Aboriginal Medical Services, working with other health and community service providers in diverse regions of Australia, to create and implement a culturally and locally-appropriate model that incorporated such an approach.

Aboriginal and Torres Strait Islander women returning home after serving a custodial sentence face enormous challenges. Many are burdened by multiple long-standing health and wellbeing issues, which, like their incarceration, stem from the devastating loss of land, culture and family caused by colonisation and the social, economic and educational disadvantage that continues today. Health problems include substance misuse, mental disorders, blood-borne viruses (including hepatitis A and B) and chronic diseases such as diabetes and



cardiovascular disease. These make it even harder for the women to deal with all of the requirements of returning to their home, meeting their basic social, emotional and physical needs and re-establishing roles and relationships with their families and communities (SPRINT Project Team, 2013).

Project aim

The service agreement between the Department and the three implementing organisations, described the project aim as follows:

“to provide support to Aboriginal and Torres Strait Islander women returning back into the community from their recent custodial sentence. This includes providing culturally appropriate support and guidance to enable engagement and connection with relevant service providers in the area of primary health care (including AMS providers), mental health services, family support officers, women health and wellbeing providers. Importantly there is a need to link health care service outcomes during custodial care to ongoing primary health care in the community. Finally the clients should be enrolled in Personally Controlled Electronic Health Record (PCEHR) program.”

Aims, Methods and Guide for reading this Report

The evaluation utilized four core processes to achieve the four aims specified in the Department of Health funding agreement, as described below.

- 1. fostering conditions for collaboration in order to enhance multi-way learning experiences with and between the three sites,*
- 2. conducting a literature review in order to identify existing processes and tools available and likely to be feasible and effective,*
- 3. undertaking three case studies by reviewing project scope and existing documentation and collecting qualitative data in order to capture the progression of plans at each site, and*
- 4. conducting a metasythesis of findings and learnings in order to advise and guide policy and practice.*

Support, information-sharing and communication approach to all sites

Following up the initial meeting (September 2013), two joint teleconferences were held with the sites where progress was discussed and ideas across sites were exchanged (November 2013 and January 2014). This provided data into the evaluation and allowed the team to consider likely needs for support and the program documentation prior to the site visits.



A face to face presentation was delivered in Canberra in November 2013, when two members of the evaluation team met with the teams from the three sites. The aim of this presentation was to share conversations about the need for wholistic, culturally appropriate, locally-tailored services and for the evaluation to have a corresponding, strengths-based approach. A number of potentially useful tools were introduced to the teams that had been developed by Muru Marri and used with Aboriginal and Torres Strait Islander people services and clients in similar situations to those faced by the *Returning Home, Back to the Community from Custodial Care* sites. The presentation also opened up discussions in response to healing and empowerment programs (e.g. the Family Well Being Program), measuring change (e.g. the Growth and Empowerment Measure), embedded accountable pathways of care for social and emotional wellbeing (the Protocols) and examples of program quality measures (the Critical Success Factors). Muru Marri's powerpoint presentation was sent to all three sites for review and use after the meeting.

The evaluation team also developed two multi-page newsletters, in December 2013 and April 2014 (Appendix A4). These were sent to the three sites and provided contributions from the fieldwork as well as from interesting and relevant programs and resources from the literature review.

An interactive group was made through Yammer¹ to maintain ongoing online communication and document sharing.

Literature and Program and Service Reviews

Literature Review

The evaluation team performed a targeted review of the relevant grey and peer-reviewed published literature to inform and evaluate models of care for Aboriginal women involved with criminal justice. Legislation and policy about health and social care and Indigenous methodologies and cultures have also been drawn on, and interpreted for implications on the design, delivery and evaluation of models of care with Aboriginal women exiting custody across Australia. The review examines the post-prison release experiences, support and needs, and identifies gaps in the evidence about post-prison release care and the prevention of recidivism. The search was purposive, rather than comprehensive, and informed by many years of experience with Aboriginal and Torres Strait Islander health research and service delivery.

¹ Yammer is a social networking service that is used for communication between invited individuals, project groups and organisations.



In order to be most directly applicable for the *Returning Home Back to Community from Custodial Care* project, the literature review introduces, and then is structured to reflect the key components of a well-known model of post-release care developed by Snufflebeam (2003) modified by Williams (2014) to create the Ngaa-bi-nya² framework. Ngaa-bi-nya adapts concepts and terminology from Stufflebeam's model to better fit Aboriginal and Torres Strait Islander language and perspectives, for example, highlighting Landscape (as context), Resources (as inputs), Ways of Working (as processes) and Learnings (as products).

The complete literature review and references are included in Chapter 2 of this document.

Preliminary review of programs and services

The search for tools to inform the development of models of care led to search for existing programs and services that could provide an insight to the services and program environment to Returning Home, and other evaluation frameworks for models of care for Aboriginal women exiting custody across Australia.

A preliminary listing of identified programs and services was shared with the three sites in Newsletter No. 2 to show the breadth of programs within the field (see Appendix A4).

Further detail on the development of the programs and services preliminary review and initial insights are included in Appendix A5.

Three Case Studies

The evaluation team facilitated a case study documentation process that tells the story of the progression of plans at each of the three locations, starting at the initial meeting, followed by the joint conference calls, site-specific calls and visits to each of the sites. Original project scopes, needs assessments, proposals, existing documentation and resources produced at each site were reviewed. In depth individual and group interviews with teams, managers and key stakeholders were conducted, with at least two evaluators present at each. As each site had varying needs, time and stakeholder availability, challenges, activities and levels of implementation, a tailored, site-specific approach was used for data collection. Full details of the evaluation methods can be found in the case study reports.

² Ngaa-bi-nya is a Wiradjuri verb for examine, try, evaluate (Grant and Rudder, 2010).



The individual case study reports are provided in the Appendices: Goldfields-Midwest Medical Local (GMML RH) in Appendix 1; Townsville-Mackay Medicare Local (TMML-RHCCC) in Appendix 2, and Aboriginal Medical Service Western Sydney (AMSWS Back to Community) in Appendix 3.

Cross-case Analysis

This diversity of experience provided an unexpectedly rich account of barriers, enablers, strategies to overcome them, solutions and achievements. A cross-case analysis was conducted to identify and explore key determinants of success, and potential outcomes that can be achieved when structural and organizational barriers are overcome. Recommendations are provided where clear messages for policy and practice emerged from the analysis findings.

The cross-case analysis and recommendations are provided in Chapter 3.

Metasynthesis and Ngaa-bi-nya evaluation framework

The final task for the evaluation team was to “conduct a metasynthesis to bring together the learnings from the project teams’, stakeholders’ and communities’ experience and the literature review and then distill them into a highly informed guide for policy and practice that promotes the likelihood of the program being sustainable and supported to meet its full potential in other sites” (Muru Marri project plan 2013).

The Ngaa-bi-nya framework introduced in Chapter 2 is used in Chapter 4 as a basis for synthesizing the literature review and the cross case analysis of learnings from the project. It serves as an evidence-based guide to policy and practice that highlights enduring principles as well as and flexible delivery processes that can be applied in other settings.

The framework also provides a basis for data collection that reliably indicates the extent to which effective mechanisms are in place to assist the women, assesses their feasibility and sustainability and promotes continuous quality improvement. It also suggests instruments and data collection processes to capture process, impact and outcome at the level of the individual woman accessing the service, the services implementing the Returning Home program and tools and the larger community.

Chapter 4 presents the metasynthesis, summarises key learnings, suggests appropriate evaluation frameworks and highlights key messages for enhanced policy and practice to promote post-release care that helps Aboriginal women to re-establish themselves in their communities with effective support and service networks.



2. Review of the Evidence

Part A. Literature Review

Introduction

This chapter details a framework for informing and evaluating models of care to support Aboriginal women in Australia exiting correctional facilities. Australian Aboriginal women experience among the highest rates of incarceration and recidivism in the world. Rates have increased in the last two decades. This is despite a Royal Commission into Aboriginal Deaths in Custody which also examined incarceration and recidivism rates, several iterations of Federal and State policies, variations in funding allocations and increases in research. The worsening situation compels us to more closely consider the historical and contemporary context in which the incarceration of Aboriginal women is experienced, with critical reflection on models of care that have previously been implemented as well as recommended; however under-evaluated and overlooked. Critical reflection on factors in Aboriginal women's incarceration highlights that they have complex needs compounded by poor health and determinants of health. They often have been victims of crime, been heavily penalised for breaches to State-enforced administrative orders, and have pressing roles in family care-giving and the wellbeing of our next generations.

There is an urgent need for focused research and uptake of research findings that can lead to improvements in the extremely poor circumstances and enormous challenges facing Aboriginal women returning home from prison.

Background: increasing prison rates highlight the need for sensitive and effective models of care and evaluation

Australian Aboriginal women experience among the highest rates of incarceration and recidivism in the world. Rates have worsened in the last two decades to 368.5 per 100 000 of the adult population, 16 times over-represented compared to non-Indigenous people and to 13 times for Aboriginal men (Bartels, 2010; Australian Bureau of Statistics (ABS), 2009). Aboriginal and Torres Strait Islander people represent on average 27% of prisoners across Australia (ABS, 2013) while only 2.5% of the total community population (ABS, 2012). This is despite actions in the areas of criminal justice and health – a Royal Commission into Aboriginal Deaths in Custody which also examined incarceration and

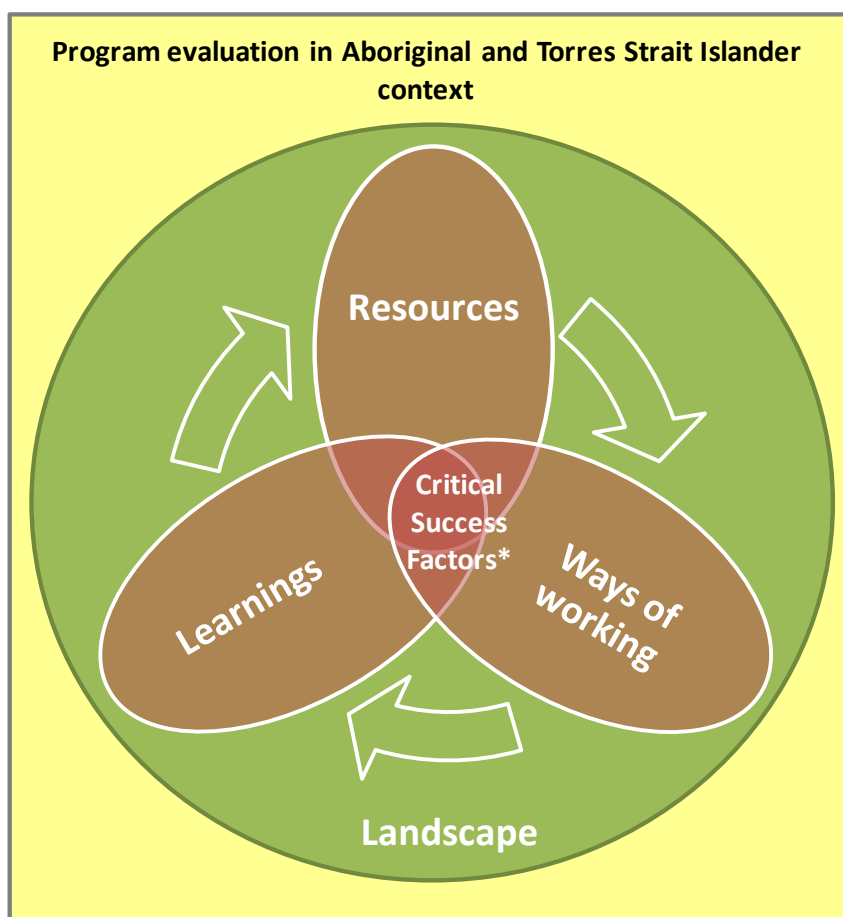


recidivism rates, an intergovernmental strategy 'Closing the Gap' to improve determinants of health, and increases in research. An opportunity now exists to guide and appropriately evaluate models of care to support the health and wellbeing of Aboriginal women exiting custody, addressing some important issues that lead to recidivism and contributing to lower rates of imprisonment. Australia's federal government, through the Department of Health and Ageing, has allocated funding to three health services in geographically and demographically different areas in Australia, to develop the models of care and implement services for Aboriginal and Torres Strait Islander Women who are returning home, back to community from custodial care - the 'Returning Home' project. The evaluation initially aims to assess the models of care. The evaluation team from Muru Marri at UNSW Sydney, brings considerable and varied experience in program evaluation, service delivery, and research in the criminal justice system. A review of programs delivered for Aboriginal and Torres Strait Islander people exiting custody conducted by Muru Marri highlights the significant lack of research on programs processes, outcomes and impacts. Much of this valuable work is informal and undocumented. The evidence-base on which to plan, design and deliver services for is theoretically and empirically underdeveloped, particularly in light of the enormous social and economic costs associated with re-incarceration. Much greater research in this area is required, particularly research that includes Aboriginal and Torres Strait Islander people, Aboriginal and Torres Strait Islander culture and worldviews.

This chapter is both a review of literature about post-prison release experiences, support and needs, and a commitment to better developing the evidence-base about post-prison release care and to preventing recidivism. Peer-reviewed and grey literature, legislation and policy about health and social care, Indigenous methodologies and cultures have been drawn on, and interpreted for implications on the design, delivery and evaluation of models of care with Aboriginal women exiting custody across Australia.

We propose a framework to guide design, delivery and evaluation of models of care and evaluation, the Ngaa-bi-nya model, which interprets and develops the Context, Input, Products and Processes model by Stufflebeam (2003). The model is modified in order to enhance alignment with Aboriginal and Torres Strait Islander programs and settings. It has been previously trialed by Muru Marri and importantly, is transferable to other programs and services designed to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

The Ngaa-bi-nya framework and its sub-sections Landscape, Resources, Ways and Learnings is depicted below, and is used to structure this paper.



Ngaa-bi-nya evaluation framework, adapted from the Context, Input, Products and Processes model by Stufflebeam (2003). *Critical Success Factors (Haswell, Blignault, Fitzpatrick and Jackson Pulver, 2013)

In relation to **Landscape**, this paper begins by outlining current rates of incarceration and recidivism of Aboriginal and Torres Strait Islander women, determinants of health which largely reflect risks for incarceration and re-incarceration, as well as post-prison release needs. Landscape also considers settings and circumstances of local communities, important to the Returning Home project, where services are offered in three very diverse sites. In relation to **Resources** used, the evaluation will identify knowledges, funding, people power, stakeholders, data records, plans, equipment, evidence, theory and time provided to the support Aboriginal women in the families and communities. Working with Aboriginal and Torres Strait Islander peoples demands singular and diverse practices. These have been well-identified into values and principles published elsewhere as valuable guidelines (Haswell, Blignault, Fitzpatrick and Jackson Pulver, 2013; Australian Institute of Aboriginal and Torres Strait Islander Studies, 2012; NHMRC, 2003; Eckermann, 2005). In the **Ways of working** aspect of the evaluation, activities, practices, values, relationships, management, methodologies, reflections, systems and accountability will be



examined. Because of the wholistic notion of Aboriginal and Torres Strait Islander health and wellbeing, and the frequent interconnectedness between Aboriginal and Torres Strait Islander families, Elders and service providers (Williams, 2011) Ways of working overlaps with but is also distinct from Learnings. **Learnings** are processes in which incremental progress is made, often an important achievement in itself in Aboriginal and Torres Strait Islander health and social services, when acknowledging that positive impacts are often not immediately discoverable. This particularly applies to Aboriginal and Torres Strait Islander because of the considerable burden of disadvantage they experience, which must be overcome when achieving significant successes and sustainability.

The Landscape of Aboriginal women's incarceration and release: The world's highest rates?

Incarceration and re-incarceration of Australian Aboriginal and Torres Strait Islander peoples

In Australia, the number of people in full-time correctional centre custody has more than doubled in the last ten years (Steering Committee for the Review of Government Service Provision (SCRGSP), 2009; Walmsley, 2009); incarceration of females increased by 60% from 2000 and 2010 compared to 35% among males (ABS, 2010a). Rates of incarceration have continued to grow despite crime rates decreasing or remaining stagnant (Australian Institute of Criminology, 2006; Western, 2006). Prison population growth rates are well above population growth rates in Australia (ABS, 2013b).

In addition to overall prisoner numbers in Australia continuing to increase, involvement of Aboriginal and Torres Strait Islander people in the criminal justice system has "worsened" to the point where they now experience a 15-fold over-representation in prison, compared to a 10-fold over-representation in 2000 (ABS, 2013c; SCRGSP, 2009, p. 7). The age-standardised rate of imprisonment of Aboriginal and Torres Strait Islander people as at 30 June 2013 was 1977 per 100 000, compared to 131 per 100 000 for non-Indigenous people (ABS, 2013c).

The rate of Aboriginal and Torres Strait Islander incarceration is almost triple the highest rate of incarceration of any of the 216 countries ranked in the world, with the US the highest at 743 per 100 000 (International Centre for Prison Studies, 2010). The incarceration rate of the general Australian population ranks Australia relatively low at 103; the Aboriginal and Torres Strait Islander rate is not separately specified (Walmsley, 2003). Rates of Aboriginal and Torres Strait Islander incarceration and re-incarceration may well be underestimated, given



the ongoing under-identification of Aboriginal and Torres Strait Islander people in mainstream government data collection (Madden and Jackson Pulver, 2009). These rates are profound given Aboriginal and Torres Strait Islander people constitute 2.5% of the Australian population (ABS, 2012)

Aggregated data hide the diversity in incarceration rates in State and Territory jurisdictions; for example 86% of people in Northern Territory prisons are Aboriginal and Torres Strait Islander (ABS, 2013c), compared to being 26.8 % of the total community population (ABS, 2012), while 7% of those in Victorian prisons are Aboriginal and Torres Strait Islander people (ABS, 2013), compared to being 0.7% in the community population (ABS, 2012). In one prison in Western Australia, of 69 women incarcerated at Greenough Regional Prison 95% identified as Aboriginal (Medicare Local Goldfields-Midwest, 2013) yet Aboriginal people comprise just 3.1% of the total community population (ABS, 2012).

Over three quarters (77%) of Aboriginal and Torres Strait Islander people in Australian prisons have previously been incarcerated, compared to over half of all people in prison (58%), both these rates rising from previous years (ABS, 2013c). The number of individuals released from prison each year greatly exceeds the number of prisoners. Return-to-prison statistics are not routinely released by governments; 44,000 releases per year was estimated over ten years ago (Baldry, McConnell, Maplestone, and Peeters, 2003). This is likely to be much higher now given the increased rate of imprisonment, and higher still for Aboriginal and Torres Strait Islander people. Prison census data from 1993 and 2001 shows the majority exit after the second sentence of incarceration, but a proportion go on to do several more 'spells' (Rawnsley, 2003); little is known about the recent experience of Aboriginal and Torres Strait Islander people but multiple re-incarcerations have been found in sub-populations of Aboriginal and Torres Strait Islander people (Kinner, 2006a). Recidivism rates among Aboriginal and Torres Strait Islander people did not reduce in the decade to 2009 (SCRGSP, 2009; ABS, 2008), as measured by return to prison. Recidivism rates are likely to be higher if measured also by re-arrest, reconviction or resentencing rather than just return to custody (Langan and Levin, 2002).

Probability of recidivism among Aboriginal males in a Western Australian study over ten years from 1975 and 1984 was 80% compared to 48% for non-Aboriginal males, and 75% compared to 29% for females (Broadhurst, Maller, Maller and Duffecy, 1988). Higher mortality rates of Aboriginal men, compared to non-Aboriginal men, partly explain why fewer males over-35 years of age return to prison (Broadhurst, Maller, Maller and Duffecy, 1988). Many recidivists are re-incarcerated due to breaches to correctional orders, rather than 'new' crimes in the community (Jones, Hua, Donnelly, McHutchinson, & Heggie, 2006).



Almost half (42.3%) of all prisoners serve relatively short sentences of between one and five years meaning that release from prison is imminent for many; those serving life in prison represent a minority of all prisoners at 3% (ABS, 2009).

In Australia risk of re-incarceration is now associated with being Indigenous (Zhang and Webster, 2010). It is one's very cultural identity as an Aboriginal and Torres Strait Islander person that is construed as a risk factor (Brough et al, 2004). Broadly in the field sociology, anomie (Merton, 1957), strain theories, and sub-cultural theories (Cohen, 1955; Matza, 1964) have been used to explain minority groups', including Indigenous peoples', engagement with the criminal justice system, recognising the impact of social disadvantage, disconnection experienced in relation to general society, and breakdown of cultural norms and bonds between individuals and their communities. Too few critical discussions, sensitive research, interventions nor evaluations seek to understand this any further.

Addressing underlying determinants of health and incarceration

In Australia, one of the biggest shifts in recent years has been acknowledgement of the contribution of poor social determinants of Aboriginal and Torres Strait Islander peoples' experience of health inequity. This is reflected in a major Council of Australian Governments (COAG) strategy to reduce inequity across these determinants, in an effort to reduce inequity in health outcomes such as mortality. This strategy is called 'Closing the Gap' in light of Aboriginal and Torres Strait Islander people dying on average 13-17 years earlier than others in Australia (Council of Australian Governments, 2010). Several targets have been set for education and employment; but no targets have been set for the criminal justice system (SCRGSP, 2009). Whilst welcomed, Closing the Gap solidifies a 'whole of government' approach to channel Aboriginal and Torres Strait Islander peoples' affairs into mainstream systems, failing to recognise the value of the Aboriginal and Torres Strait Islander community-controlled health and not-for-profit sectors (Sullivan, 2011, pp. 48-66).

Aboriginal and Torres Strait Islander people today continue the bloodlines and traditions of Earth's oldest continuing cultures, with connections dating back over 40 000 years. Prior to invasion and colonisation by British forces from 1788, the life of Aboriginal people was characterised by social, environmental and economic diversity (Franklin and White, 1991). Whether inland or in coastal regions, early records show Aboriginal people generally enjoying sound health, supported by a mixed economy that relied on hunting, fishing and gathering. Close spiritual relationships with land, detailed knowledge of natural resources and adaptive skills contributed to survival and the good standard of living, with strong kinship laws prescribing relationships and social roles. Great diversity



has long existed, with over 300 distinct language groups and differences related to geography, history, cultural practices and resources (Horton, 1994).

From 1788, land, food and water was appropriated by colonialists for their own use, repelling, attacking or imprisoning those who resisted, and exiling families from their ancestral homelands. Mandatory relocation of people onto reserves and missions, dislocation of families, premature death of Elders, interruption of traditional education practices, and transmission of knowledge, language and customs have resulted in multiple generations affected by grief and trauma. The legacy of high rates of incarceration, diseases and disruption to cultural norms, combined with political and economic marginalisation made explicit through government policies of protectionism, segregation and assimilation continue to negatively impact on Aboriginal and Torres Strait Islander peoples' lives (Human Rights and Equal Opportunities Commission, 2007). Aboriginal and Torres Strait Islander people experience the poorest socio-economic position of all Australians (Carson, Dunbar, Chenhall and Bailie, 2007).

Health and social status

Diseases and conditions having a major impact on Aboriginal and Torres Strait Islander peoples today include circulatory system diseases (including heart disease and stroke), injuries (including transport accidents, intentional self harm, assault), neoplasms, respiratory system diseases and diabetes. Overall rates of hospitalisation are two and half times that of non-Indigenous people (ABS, 2013d).

Deaths of Indigenous people occurred two to four times more frequently than that expected from the age-sex-specific death rates in the total population (ABS, 2009). Leading causes of death are cardiovascular disease, injury and poisoning, cancer, respiratory conditions and diabetes (Australian Bureau of Statistics (ABS) & Australian Institute of Health and Welfare (AIHW), 2010). The highest death rate ratios between Aboriginal and non-Indigenous Australians are found among young and middle aged adults (ABS, 2013d).

Aboriginal and Torres Strait Islander people are almost twice as likely to be hospitalised for mental and behavioural disorders as other Australians (AIHW, 2010). From 2001 to 2005, Indigenous males were 5.8 times more likely and Indigenous females 3.1 times more likely to die from such disorders than non-Indigenous people (ABS & AIHW, 2010). In 2003–07, death rates from intentional self-harm were also higher (SCRGSP, 2009). On average, Aboriginal and Torres Strait Islander people die from suicide at much younger ages than non-Indigenous people (SCRGSP 2009). Aboriginal and Torres Strait Islander people are exposed to stressful life events to a much greater degree than other Australians; risk exposure varies by location (ABS, 2010b; AIHW, 2010). Racism



and discrimination are the ongoing legacies of the policies of colonisation (Durey, Lin and Thompson, 2013; Anderson, 2013), including in health care settings, and this can "damage health and lead to a reluctance to access health services" (Taylor, cited in Durey, Lin and Thompson, 2013, p. 722).

Poor health and wellbeing extends from prison to community

The poor health and social status of Aboriginal and Torres Strait Islander people has been clearly demonstrated through decades of research. Even generally, all populations of prisoners are regularly "characterised" in the literature as being of poor health and experiencing "extreme disadvantage" (Butler, 2008, p. 2). Current trends suggest that prisoner health, wellbeing and determinants of health are worsening (AIHW, 2010; ABS, 2010b). Health adversity is "incurred" by Aboriginal and Torres Strait Islander people through incarceration, because of separation from family and culture, isolation and re-traumatisation, and exacerbation of existing health conditions (National Indigenous Drug and Alcohol Committee, 2009). Many studies internationally indicate that social disadvantage contributes not only to health status but to crime and recidivism (Western, 2006; Urbis Keys Young, 2004; Gendreau, Little and Goggin, 1996).

Australian studies have clearly shown for some time the pronounced social disadvantage Aboriginal and Torres Strait Islander people experience on both sides of the prison gate. For example, Weatherburn, Snowball and Hunter found that Aboriginal and Torres Strait Islander people were "far more likely to have been charged with, or imprisoned for, an offence if they... failed to complete Year 12 or were unemployed... experiencing financial stress, living in a crowded household and being a member of the 'stolen generation'" (2006, p. 1). Willis and Moore's (2008) study of almost 9000 males incarcerated for violent offences showed that 37% Aboriginal and Torres Strait Islander men had less than a Year 9 level of education compared with 21% of non-Indigenous prisoners, and less than 7% had completed Year 12 compared with 16% of non-Indigenous prisoners. In a qualitative study involving most Aboriginal males in a South Australian prison, Krieg (2006) and colleagues found that 90% relied on government welfare payments, 5% had some employment, and 5% had no income at all.

The disadvantages outlined here extend from pre-prison to post-release. These are the underlying factors that need to be addressed in post-release care, and more broadly (Kinner and Williams, 2007; Project 10%, 2010). Post-release services must be oriented to tackling socio-economic determinants. However, the evidence base is still lacking on determinants deemed important by Aboriginal and Torres Strait Islander people, such as connectedness to country and family, cultural identity, roles and racism. Post-prison release services may well be limited in the extent they can sustainably improve determinants, given



that disadvantage and exclusion of Aboriginal and Torres Strait Islander people is historical and broader than the criminal justice and health systems. Adequately resourcing and evaluating the policy frameworks responsible for health and criminal justice will help ensure they are implemented to bring about improvements to Aboriginal and Torres Strait Islander health and wellbeing (Calma, 2007).

Investigating social support post-prison release

An important social determinant of health relevant to the post-prison release period is support. Social support is one of the key independent determinants of health (Baum, 2002), thought to be particularly relevant to the traditionally collectivist communities of Indigenous peoples (Mignone, 2011). It has also been identified as a dynamic factor significantly associated with reducing recidivism, increasing desistance from crime (Cullen, 1994) and increasing 'survival time' in the community post-prison release (Brown, Amand and Zamble, 2009).

Very little research about post-prison release social support among Aboriginal and Torres Strait Islander people has been published. Traditionally, post-prison release support is outside the jurisdiction of prison authorities, and while this is changing (Kinner and Williams, 2007) has neither been located within the mandate of health or community services nor Aboriginal and Torres Strait Islander affairs. Social support provision by Aboriginal and Torres Strait Islander services in general is under-researched, and overlooked. The exception to this is the long history of Aboriginal and Torres Strait Islander community-controlled health services (CCHOs) in Australia, with holistic, locally-led models of comprehensive primary health care and much higher levels of engagement, episodes of care and cultural sensitivity than the mainstream health system (Couzos and Murray, 2008; Aboriginal Medical Services Alliance Northern Territory, 2007). Approximately 150 CCHOs exist around Australia, and despite their success are considerably under-resourced in light of the poor health outcomes experienced by Aboriginal and Torres Strait Islander peoples (Dwyer, O'Donnell, Lavoie, Marlina et al., 2009; National Aboriginal Community Controlled Health Organisation, 2009) and relatively low levels of access to mainstream services (Hayman, 2010; Scrimgeour and Scrimgeour, 2008). Poor access to health and support services is generally also the experience of ex-prisoners (SPRINT Project Team, 2013; Krieg, 2006; Goulding, 2004). The next part of this paper turns to examine the types of programs and services that have traditionally been used in the criminal justice system to support people exiting prisons, and to reduce poor outcomes such as recidivism.



Resources: What does the literature say is needed to improve post-prison outcomes?

Gaps and needs of prisoners drive the responses

Increases in prison numbers and lack of quality rehabilitation and support options have occurred despite international instruments stating that prisoners have the right to rehabilitation appropriate to their age, legal status and with respect for their dignity (United Nations, 1976); from the beginning of their sentence, to health care, with special attention to improve relationships with family and community, preparation for work life, education integrated with the community, cultural activities and coordinated after-care (UN, 1955). These build on the 1955 United Nations Standard Minimum Rules for the Treatment of Prisoners asserting that prison aftercare should be considered from the outset of a sentence. This 'throughcare' is echoed in legislation and commentary around Australia but is rarely seen in practice (SPRINT Project Team, 2013; Segrave and Carlton, 2011; Shinkfield and Graffam, 2009; Kinner, 2006a; Golding, 2004; Ross, 2003). The SPRINT study conceptualised three stages to throughcare, each stage requiring a different approach: In-custody, pre-release and post-release (SPRINT Project Team, 2013). Research in these phases is discussed below. Issues, gaps and needs are interpreted as potential action areas for which resources are required in future models of care.

In-prison

As described earlier, Aboriginal and Torres Strait Islander people in prison have poor health, which worsens due to institutionalisation, isolation from family and country. In-prison programs are often criticised for being insufficiently designed to take into account cultural protocols, processes and knowledge of Aboriginal and Torres Strait Islander people (Anaya, 2010; Baldry, 2009; Johnston, 1991). Programs are often inappropriately facilitated by non-Indigenous staff (Project 10%, 2010), with few Aboriginal and Torres Strait Islander staff employed, cultural awareness training lacking with no mandatory requirements (SPRINT Project Team, 2013) and minimum standards of staff cultural awareness training being too basic to understand the complex needs Aboriginal and Torres Strait Islander people face post-prison release (Project 10%, 2010).

Delivery of prison programs is constrained to increasingly punitive environments (Ward and Maruna, 2007), which in nature are disempowering and contribute to poor health (de Viggiani, 2007). Often such programs and rehabilitation interventions are criticised for being under-resourced (Western, 2006), too focused on individual-level change (Ward and Maruna, 2007), and fail to address community-related contextual factors and outcomes (Farabee, 2005; Cullen, 2002; Borzycki, 2005), including those that Aboriginal and Torres Strait



Islander people experience such as leaving prison with financial debt, fear, anger and disconnectedness from civil society (Poroch, 2007).

Prisoners generally have the right to the same access to health care in prison as they do in the community; health services are provided either by State and Territory prison or health authorities. However, Aboriginal and Torres Strait Islander CCHOs funding arrangements in part occur through federal arrangements, frequently using the public coverage scheme, Medicare. Prisoners in Australia do not have access to Medicare, a very real barrier for ensuring that Aboriginal and Torres Strait Islander people will have access to CCHOs, continuity of health care that they experience in the community, or opportunities to develop relationships to influence care post-release. This is also a barrier for “community health service providers to provide in-reach services to Aboriginal inmates and it also prevents outreach services.” (SPRINT Project Team, 2013, p. 25). Vast geographic distances between many prisons and Aboriginal and Torres Strait Islander communities prevent Elders, family members and other supports from visiting (Alexander, Martin and Williams, 2011); although in-prison visits have been positively associated with greater support in transition from prison, lower recidivism rates and perceived support (Solomon et al., 2006).

Pre-release

In terms of preparation for release, various instruments are used to predict who is most likely to become troubled or re-incarcerated in the months after prison release. Andrews and Bonta’s (2003) classification of ‘static risk factors’ such as prior incarceration, and ‘dynamic risk factors’, also known as criminogenic needs and including drug and alcohol use and employment are frequently used. Dynamic risk factors are often the subject of criminal justice interventions because they are relatively discrete issues thought to be targeted through treating individuals in prisons (Gendreau, Little and Goggin, 1996). These have not been validated among Aboriginal and Torres Strait Islander populations.

Research appears inconsistent and inconclusive as to whether addressing criminogenic or dynamic risk factors through treatment or rehabilitation is effective at reducing criminal behaviour and recidivism. On the one hand, a meta-analysis of 131 studies published from 1970 to 1994 showed that dynamic variables were “relatively weak predictors of criminal behavior” (Gendreau, Little and Goggin, 1996, p. 576). On the other hand, a review of over 200 rehabilitation studies published between 1981 and 1987 concluded that rehabilitation of offenders can in fact reduce recidivism (Gendreau and Ross, 1987). Despite this inconsistency, generally programs targeting dynamic risk factors are expanding (Andrews and Bonta, 2003; Cullen and Gendreau, 2000).



In the limited research specifically related to Aboriginal and Torres Strait Islander people, criminogenic needs have been identified that differ to mainstream Australian populations, including anger related historical and intergenerational trauma (Day et al. 2006; Jones, Masters, Griffiths and Moulday, 2002; Mals, Howells, Day and Hall, 2000). In Gendreau, Little and Goggin's (1996) meta-analysis, variables related to personal distress, however, were not found to predict recidivism. They did find that family factors such as early childhood trauma and disadvantage predict recidivism (Gendreau, Little and Goggin, 1996), which reflect the reality of many Aboriginal and Torres Strait Islander families disrupted by colonisation, forced removal of children and erosion of cultural processes (Human Rights and Equal Opportunity Commission, 2007).

Many people leave prison with unmet health and psychosocial needs, including risks for alcohol and drug dependence and mental health issues (Willis and Moore, 2008; Clear, Rose, Waring and Scully, 2005; Kinner, 2006a; Kinner, 2006b). These reduce chances of successful reintegration post-prison release and have been associated with recidivism (Hochstetler, DeLisi and Pratt, 2010). Many people leave prison without concrete plans for even daily living, such as stable accommodation or income (Kinner, 2006a; Kinner, 2006b; Schram, Koons-Witt, Williams and McShane, 2006; Visher and Mallik-Kane, 2007). The SPRINT study found "Poor linkages, communication and planning between prisons and community health services. A lack of intersectoral collaboration means that upon release Aboriginal Australians are left wanting..." The SPRINT study recommended clear 'duty bearers' – a "single agency responsible for supporting transition from prison to the community." (SPRINT Project Team, 2013, p. 26).

The needs and gaps discussed in this section are all potential action areas for post-prison release models of care. Quality needs assessments of individuals, scoping of their support networks, health literacy and self-management and communication skills, as well as efficacy at accessing services, must be undertaken at local levels, sensitive to the experiences of Aboriginal and Torres Strait Islander peoples. Evaluation that captures such processes, instruments and outcomes is necessary to share that information more broadly and across time, and builds future Aboriginal and Torres Strait Islander research and evaluation capacity alongside service delivery expertise.

Post-release

Along with the increase in prison numbers and beds, a weakening and reduction in availability of post-release support programs has occurred (Travis, 2000). Whilst many services are available in the Australian community, Aboriginal and Torres Strait Islander people experience very real barriers to accessing these, as do ex-prisoners, and needs outstrip availability of culturally sensitive care.



However, from the 1950s to 1970s a prisoner was thought to be closely assisted with re-entry plans and was often released to a halfway house with a caseworker, volunteer support and careful community supervision (Seiter and Kadela, 2003). A ‘new penology’ has emerged (Feeley and Simon, 1992) that manages ever-growing prisoner numbers by ‘aggregating’ them together and dealing with them “...in a simplistic input-output, businesslike fashion...” (Gendreau, Little and Goggin, 1996, p. 576). Comparatively few part-time transitional release programs or halfway houses are available compared to numbers of people entering and exiting prisons, and their complex needs (Seiter and Kadela, 2003; Petersilia, 2003).

Upon release, people face many of the same problems, or worse, that lead to incarceration in the first place (Baldry, 2009; Johnston, 1991). People have complex needs and challenging behaviours when they exit prison (SPRINT Project Team, 2013; Bartels, 2010; Kinner, 2006a; Kinner, 2006b; Rose et al 1993), and face a process of de-institutionalisation. The SPRINT study found high levels of vulnerability, trauma and emotional distress; increased risk of relapse to substance misuse and risky behaviours post release, and complex health issues.

In addition to poor health and wellbeing, ex-prisoners have disproportionately high rates of death in Australia (Borzycki, 2005; Graham, 2003; McGregor, Ali, Lokan, Christie, & Darke, 2002; Darke, Ross, Zador, & Sunjic, 2000), and overseas (Farrell & Marsden, 2005; Singleton et al., 2003; Bird & Hutchinson, 2003; Shewan, Hammersley, Oliver, & Macpherson, 2000). This risk is particularly high for Aboriginal and Torres Strait Islander ex-prisoners (Kariminia et al., 2007; Kinner, 2006a; Stewart, Henderson, Hobbs, Ridout & Knuiman, 2004). The main causes of death are “both tragic and preventable: fatal drug overdose, suicide and accidents” (Kinner, 2007/08, p. 585).

Added trauma of institutionalisation and exclusion from community (Segrave and Carlton, 2011) and erosion of parental roles (Brown and Bloom, 2009) mean that damage to health, employability, relationships, families and resilience are not intended outcomes of incarceration, but are the reality for many. These are at once serious impediments to individual-level rehabilitation or healing, and community reintegration, and as noted earlier they are the same risk factors for crime and recidivism. Aboriginal and Torres Strait Islander people have a strong need to reconnect with family, community and culture (SPRINT Project Team, 2013). Where offenders have experienced “a long pathway of social deprivation, stunted life options and emotional and physical abuse” (Ross, 2003) it should be expected that reintegration will take a long time. In the US an ‘underclass’ of young African-American males exists, whose education, economic participation and social connections are thought to be forever disturbed by incarceration



(Western, 2006). Research among Aboriginal male inmates in a South Australian prison concluded that:

When basic needs such as shelter and a secure source of income are out of reach, the incentive and capacity to attend ongoing medical and counselling appointments, maintain medication regimens and adopt healthy lifestyle practices are severely compromised.

(Krieg, 2006, P. 535).

Even when individuals have received adequate health services while in prison, they often face limited access and insufficient linkages to community-based health care on release (Hammett, Roberts, & Kennedy, 2001). The general community continues to harbour its dislike for criminals, whether or not they have 'done their time' in prison (Tonry, 2013) and despite how poorly they are faring in the general community and affecting public health and economy. It is not surprising then, that Baldry (2009) describes people as existing in a "liminal space" post-prison release – at once living again in the community, but marginalised outside the general community, and only a short distance from recidivism and a longer-term prison sentence and setting. This liminal space

...does not afford access to stable support and services in either place and in fact promotes serial institutionalisation. It is a combined marginal community and marginal criminal justice fluid space in which many such vulnerable persons are caught.

(Baldry, 2009:21).

This paper now turns to the considerable expertise that Aboriginal and Torres Strait Islander health care workers and researchers have for engaging seriously disadvantaged community members, and conducting culturally-informed health promotion, healing and crime prevention programs. The next sections draw on material outside the criminal justice system, to include research and reviews about 'what works' in support of Aboriginal and Torres Strait Islander peoples, and their critical success factors.

Ways of working: Tuning in to Aboriginal and Torres Strait Islander peoples' experience

Role of community

Throughout modern criminology, the community has been named as critical in contributing to crime, whether through childhood disadvantage, socioeconomic disadvantage or politically charged punitive punishment for perpetrators (Petersilia, 2003). The community is also recognised as having an important role



to play in preventing crime, including among those who have already been incarcerated, and then released. Social influences or structures that assist in desistance from crime include educational institutions, families, social services and opportunities for civic participation (Hochstetler, DeLisi and Pratt, 2010), which are important opportunities for community reintegration (Clear, Waring, & Scully, 2005; Laub & Sampson, 2003; Maruna & Toch, 2005; Petersilia, 2003; Sampson & Laub, 1993; Visser & Travis, 2003).

However, services on offer for desistance from crime are generally focussed on individuals and rarely offer the opportunity for Aboriginal and Torres Strait Islander families or communities to be involved in the complex pathways to crime, preventing recidivism, nor healing and tackling social determinants of health and crime (Project 10%, 2010). Maruna, Immarigeon and LeBel (2004) propose clearer investigation of the potential of interpersonal support in desistance from crime, particularly the role family and friends.

Ecosocial, wholistic models

Ecosocial models explain the multiple levels and directions that social support post-prison release is contextualised in. Research and commentary by Maruna, Immarigeon and LeBel (2004), and Maruna (2001) in particular have extended thinking about post-prison release community 'reintegration' as being well beyond the individual's responsibility to fit into society, but to also include supportive family life, opportunities for civic participation, and development of social capital in communities to provide for the needs of people leaving prisons. Shinkfield (2006) produced an ecological framework to explain how the many varied individual and social factors interact to influence successful community reintegration post-prison release (see also Shinkfield and Graffam 2009, 2011; Graffam, Shinkfield, Lavelle and McPherson 2004). This was in part borne out of a previous Australian study identifying six important domains in reintegration (Graffam, Shinkfield, Lavelle and McPherson, 2004) and also an assessment by Visser and Travis (2003) stating that longitudinal lifecourse research is most beneficial for understanding the dynamics and complexity of post-prison release reintegration. The largely anthropological study involved surveys completed by 79 people one month prior to prison release, 36 people 1-4 weeks post-prison release, and 19 people 3-4 months post-prison release. Three conditions were surmised for "successful" reintegration – 1) meeting intrapersonal conditions including health and skills development and managing substance use, 2) subsistence conditions including housing, employment and income security, and 3) support at formal and informal levels in the health, welfare and criminal justice sectors (Shinkfield, 2006; Shinkfield and Graffam, 2010). The study did not specify experiences or factors in reintegration for Aboriginal and Torres Strait Islander people, however.



The Aboriginal and Torres Strait Islander concept of health is a living example of holism, and fits an ecosocial model. The Aboriginal and Torres Strait Islander definition of health takes ‘whole-of-life view’, where health is perceived not only in physical, but in social, cultural, political, psychological and spiritual terms (NAHWG, 1989). Also essential for many Indigenous Australians, in both traditional and contemporary contexts, is the connection to land and place, for cultural identity and knowledge about life purpose (Garvey, 2008).

In Aboriginal and Torres Strait Islander health and social services more broadly, programs are most successful when community members have power over decisions regarding program governance, design and delivery, include capacity building of community members to address issues and needs, and are aligned in cultural practices and values (for example, Haswell-Elkins et al. 2009; Couzos and Murray, 2008; Calma, 2007; Poroch, 2007; Dwyer, Silburn and Wilson, 2004).

Aboriginal and Torres Strait Islander health services and the roles and practices of health workers frequently involve the provision of direct care to individuals, family and the community, across generations (Bailey, Veitch, Crossland and Preston, 2006:1). Support for people exiting prisons must be coordinated, intensive, immediate and timely as well as long-term (SPRINT Project Team, 2013, Poroch, 2007; Shinkfield, 2006; Goulding, 2004).

Family as unit of intervention

The current Aboriginal and Torres Strait Islander health research agenda assert the need to move away from a focus on individuals, to consider the family being the ‘unit of intervention’ and research (Lowitja Institute, 2012). This direction concurs with local (SPRINT Project Team, 2013; Alexander, Martin and Williams, 2011; Poroch, 2007; Goulding, 2004) and international research on the importance of working with families of those in the criminal justice system (eg Solomon et al. 2006). Bazemore and Erbe (2004, p. 41) believe that it is “within informal community networks that social support has its most robust influence”. Martinez and Christian (2009, p. 201) assert that informal family support is “essential” to avoid re-incarceration”. Families have long been considered important sources of emotional and practical support, particularly to ‘buffer’ members in times of particular hardship (Irwin, 1970). Among mainstream US ex-prisoner populations, the family is often the primary agent to provide support needed during incarceration and after release (Christian, Mellow and Thomas, 2006); research has also found that former prisoners most often return to their family of origin on release (for example Visher and Mallik-Kane, 2007). Family support has been considered a ‘deciding factor’ on how successfully prisoners reintegrate into society post-prison release (Visher and Travis, 2003), and evidence generated over several decades highlights that maintaining and



strengthening family ties “positively affects post-prison outcomes...” (Visher and Travis, 2003, p. 101). The SPRINT Study Team (2013) found that family members, including siblings, parents, aunts, partners or children of former inmates, provide much support post-prison release. Trotter, Sheehan and McIvor (2006) reported among women they interviewed that by 12-24 months post-release family members were more supportive than formal service providers, in particular their mother (31%), another family member (16%), partner (14%), and also a friend (9%). Gideon (2007), though, previously found that families can have a negative effect on rehabilitation and community reintegration post-prison release. Financial burden is shifted from the state to families, pressure is often on aging parents of prisoners, and clash of values between generations is expected (Christian, Mellow and Thomas, 2006). Furthermore, a considerable body of commentary now points to communities being damaged while its members are away incarcerated (La-Vinge, Mamalian, Travis and Visher, 2003; Hagan and Dinovitzer, 1999; Clear, 2007; Western, 2006; Visher and Mallik-Kane, 2001); families and communities become more “disorganized” and often find it difficult to be supportive because of stress and scarce resources (Seiter and Kadela, 2003, p. 2). Families face great difficulties negotiating the multiplicity and complexity of services provided by the government and non-government organisations, as well as providing support to the released prisoner, particularly if they have co-morbid mental health and substance use issues (SPRINT Project Team 2013).

Learnings: Progress, outputs, outcomes and impacts of post-prison release care

Make and measure progress

Evaluable learnings are not only measurable changes as a result of program actions, but also the progress made throughout the process of change. Aboriginal and Torres Strait Islander people released from custody take many incremental steps in the process of change that are under-researched (Williams, 2008; Shinkfield, 2006; Goulding, 2004). Sensitive tools to assess for growth respect the hardships Aboriginal and Torres Strait Islander people have to overcome and the compounded disadvantage experienced by ex-prisoners. In this aspect of the Ngaa-bi-nya evaluation framework, Learnings include incremental changes in empowerment, knowledge, attitudes, beliefs and practices – depending on what the goals, objectives and indicators of the program of action were. Learnings are also the results of the activity, program or model in place, including outputs, outcomes and impacts. Learnings reflect processes too – assessing the extent to which principles for working with Aboriginal and Torres Strait Islander peoples are implemented and achieved, identifying key barriers and facilitating factors and perspectives from multiple stakeholders. These also constitute new Resources for the cycle of change to start again in a positive spiral.



This following table summarises key Learnings that the Ngaa-bi-nya evaluation framework ‘assesses’ for and the way in which these important principles and processes for working with Aboriginal and Torres Strait Islander people are evident in the context of health and social care. These Learnings are distilled from well-recognised culturally sensitive models of care, taking into account the landscape in which Aboriginal and Torres Strait Islander people live, resources available in the community, and with respect for Aboriginal ways of working. As in wholistic Aboriginal and Torres Strait Islander health and social care, overlap exists between these principles, and progress must be measured over time.



Learnings: Important features of models of care

Wholistic 1	Interconnected parts - body, mind, spirit, land, environment, custom and socio-economic status
Responsibility 2	Resourcing, accountability, working with integrity and according to Aboriginal and Torres Strait Islander values, self-determination, political advocacy, continuity, sustainability, evaluation and reporting
Cultural leadership 3	Knowledge, processes, frameworks, strengthening identity and knowledge, survival and protection, cultural sensitivity, safe spaces, contextualisation
Strengths based 4	Working from positives, not deficits, celebrating achievements
Strong relationships 5	Trust, respect, equality, reciprocity, intergenerational, inter-sectoral, communication, transfer of knowledge, linkages
Community capacity building 6	Leadership, mentoring, role modelling, guidance and strategies, individual and community, planning and actioning, transferable and applicable knowledge, decision making, access to education and training
Build infrastructure 7	Planning, housing, health, employment, transport, legal, systems, resources
Progressive 8	Reflection, innovation, managing change, sustainable, over time – past, present, future, self-determination
Spirit 9	Celebration, valuing potential, large young population to support in the future – very different to mainstream Australia
Workforce development 10	Transfer of knowledge, skills, experience, Aboriginal and Torres Strait Islander Health Workers
Evidence base 11	Contribute to this, use, critique, expand on, advocate, assess transferability
Addressing determinants of health 12	Upstream, midstream and downstream



Conclusion

This paper has reviewed the key literature pertaining to the needs and experiences of Aboriginal and Torres Strait Islander people in the Australian criminal justice system. It is clear from the existing evidence that Aboriginal women exiting prisons are among the most vulnerable in our community, and face many complex challenges, in the context of poor health and wellbeing, low levels of access to mainstream services – often while shouldering large responsibilities. Rates of incarceration of Aboriginal women have increased unabated over the last decade particularly. Legislation, policy, research and interventions designed to understand, prevent and intervene in this have been under-evaluated.

Much of the international and Australian literature is under-developed in relation to Aboriginal and Torres Strait Islander peoples' experiences. While key issues can be gleaned, the dearth of research reinforces the importance of using a sensitive and culturally informed framework to guide the development and evaluation of programs like Returning Home

As there are no adequate frameworks in the literature, we introduce the Ngaa-bi-nya which is useful, sensitive and developed by Aboriginal people immersed in justice health and initiatives that support Aboriginal people in Australia exiting correctional facilities.

The Ngaa-bi-nya framework builds on the CIPP model by Stufflebeam (2003), by taking into account key principles for engaging with Aboriginal and Torres Strait Islander people, barriers and facilitators to support service utilisation and broader actions to improve determinants of health and social status of Aboriginal and Torres Strait Islander people – acknowledging the importance of wholistic experience of health, and that the health of individuals is intertwined with the health of families, communities and Australia's social and political context.

In Chapter 4 of this document, we utilise the Ngaa-bi-nya framework to guide a metasynthesis of information from the case studies and literature review to more specifically interpret the landscape, resources, ways and learnings as a guide for other services to be better informed in their work with Aboriginal women exiting correctional facilities and returning home.



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Part B: Exploratory program and services review

An exploratory review of available information about existing programs and services was undertaken as part of Muru Marri's formative evaluation, to better understand the service environment and context to *Returning Home, Back to Community from Custodial Care*. The primary motivation was to find information about the tools and approaches used by other services, programs and practices and what was considered necessary and effective for supporting Aboriginal and Torres Strait Islander people in the criminal justice system, and particularly women. The initial aim described in the newsletter No. 2 was "to find and share a wide spread of useful information on processes and tools used in other places that may add value to the work developed in each of the sites."

1) Scoping of the review

Electronic databases, websites, grey and published literature were searched for information about programs designed for Aboriginal and Torres Strait Islander women exiting the criminal justice system.. Search strategies also included snowballing from reference lists and information from papers, conferences and printed material from the Muru Marri library. The main key words for the searches were (Aboriginal OR Indigenous) + (post-release OR release) + (prison+jail). Of most interest was information published after 2000 in Australia in peer-reviewed journals, however a wide net was cast to gather as much material as possible.

A programs and services database to record brief details of information was developed, sorted by criteria useful for the formative evaluation. Specific listings that were particularly useful source of information included:

- Indigenous justice issues in corrective services (Government of South Australia, 2009).
- Indigenous HealthInfoNet – Post-release programs (Australian Indigenous HealthInfoNet, 2014)
- Diversion programs for Indigenous Women (Bartels, 2010)
- Supporting Indigenous women across Australia (Minister for Families Community Services and Indigenous, 2013)

Further to this list, a bibliography was made to record relevant items; this is included below.

2) Review of available program information

Information was briefly reviewed and categorized according to the overall target group, whether it was Aboriginal and Torres Strait Islander-specific, women-focused, and the timing of criminal justice engagement referred to, with a focus



on transition from custody and post-release. Other details were recorded including State/Territory location and approach for the intervention. A preliminary listing of identified programs and services was made, showing the breadth of programs within the field. A wide range of more than 170 items were recorded. This highlights considerable activity in relation to Aboriginal and Torres Strait Islander people in the criminal justice system, however few were specifically related to post-prison release care of Aboriginal and Torres Strait Islander women, nor were formally evaluated.

3) Focusing the review

The next step was selection of programs working at the post-prison release stage, to look in further detail about the tools and processes used in their service delivery. These were used to inform case study analysis and included in final reporting where relevant. Data tables for the selected 141 cases are presented at the end of this section.

Learnings from the review

- **Little published evidence** is available about service delivery and programs after they are funded. That is, few formally evaluate or report outcomes.
- **Many Aboriginal and Torres Strait Islander programs cover multiple domains** – they may be at once general health programs for Aboriginal and Torres Strait Islander people, that also have an effect to promote community connections, sense of self and identity, and heal relationship – but these are not specific to ‘post-prison release care’ as such. This multiple purposing is an important feature of Aboriginal and Torres Strait Islander programs, tackling underlying determinants of health as well as working wholistically.
- **A difference between what is documented compared to what is being done in practice** was suspected at the outset of the review, and was confirmed.
- **Lack of clarity about who programs are for, and what they are doing.** At times, activities were poorly defined and therefore left open for interpretation, such as ‘mentoring’ and ‘wholistic’ care. Target groups were also often poorly defined.
- **Programs change from conceptualisation and funding to implementation**, yet this is rarely described in detail nor linked to structural processes or evaluated for impact. This fluidity and flexibility, however, is an important feature of any social or health program, operating often within short timeframes and budget constraints.



- **A lack of coordinated approaches** to programs, services or organisations was obvious, particularly with few networked organisations in the criminal justice field. This lack of coordination means missed opportunities for sharing information in a meaningful way across jurisdictions, or for coordinated advocacy, planning and reporting..

Recommendations

- Greater clearinghouse work is required to record, sort and make available Aboriginal and Torres Strait Islander community-based and criminal justice program information
- Far greater evaluation and research attention is required for the many programs and services occurring across Australia in relation to Aboriginal and Torres Strait Islander people in the criminal justice system.
- Qualifying information is required about the the extent of Aboriginal and Torres Strait Islander peoples' leadership and perspectives in program design, delivery and research, and the processes for feedback to Aboriginal and Torres Strait Islander community members.
- Greater collaboration and consideration is required about how to assess the quality of research and evidence in this area, as well as outcomes.

Program and services data tables

Table 1: Number of programs reporting Aboriginal and Torres Strait Islander 'focus'

Aboriginal and Torres Strait Islander focus	No.
Reported a focus on Aboriginal and Torres Strait Islander peoples	107
Mainstream population focus	16
Mainstream, with Aboriginal and Torres Strait Islander focus	8
<i>Not specified</i>	10

Table 2: Number of programs with gender focus

Gender focus	No.
Not gender-specific	77
Women	37
Young women	13
Men	2
<i>Not specified</i>	12

Table 3: Number of programs reporting post-prison release support provision

Post-release focus	No.
Yes	77
No	39
<i>Not specified</i>	25

Table 4: Number of programs by specified location

State/Territory	No.
Qld	28
NSW	27
Vic	23
SA	12
ACT	9
NT	9
TAS	1
WA	17
National (Australia)	3
NZ	2
<i>Not specified</i>	10

Table 5: Number of programs reporting their timing of criminal justice engagement

Stage of support reported	No.
Throughcare	18
In custody	16
Pre- and post-release	14
Diversion	11
Post-release	9
Rehabilitation	9
After sentencing	6
Community strengthening	6
Prior to contact with police	4
Pre-release	3
Parole	2
Probation and parole	3
Reintegration	2
Court processing, diversion from custody	1
<i>Not specified</i>	37

Table 6: Number of programs by approach applied

Approach/Framework	No.
Research	11
Family	9
Mentoring	9
Cognitive behavioural	9
Case management	8
Cultural	7
Life skills	7
Practical	7
Employment	6
Holistic care	6
Multiple	6
Policy	5
Sports	4
Healing	3
Court	2
Drug and alcohol	2
Legal	2
<i>Not specified</i>	38



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3. Cross-case analysis of findings from the three case studies

In this chapter we examine the diversity and commonalities of situations, experiences and learnings that each of the three RHCCC teams had in developing and implementing their care pathways. It culminates in the identification of key principles and enablers that impacted at the structural, organisational and program delivery levels, providing the rationale for the Recommendations made.

A. Project setting – Attention to Diversity

As is so typically experienced in multi-site programs focused on Aboriginal and Torres Strait Islander people, there was enormous diversity across the three settings in many important aspects associated with pre- and post-release planning (Table 1). Being located in three different states meant there were differing jurisdictional experiences, regulations, parties involved and ways of working. One organisation was urban-based and two were located in regional centres with vast catchment areas to which women returned home after release.

Two of the RHCCC host/manager organisations were Medicare Locals: TMML and GMML. TMML retained the RHCCC program but ensured that it was fully managed and staffed by highly experienced Aboriginal people. Following the initial needs assessment and service mapping, GMML subcontracted the Geraldton Regional Medical Service (GRAMS), an Aboriginal Community-Controlled Health Organisation (ACCHO), to develop and deliver the project in the Midwest region. In Western Sydney, on the other hand, the Western Sydney Medicare Local contracted the Aboriginal Medical Service Western Sydney to develop the project proposal and take the whole project forward.

AMSW's primary function is to deliver a family-centred, wholistic and multifaceted health and wellbeing service, which is strengthened through strong interest and commitment to applied research for enhancement of care. The organisation had a long-standing commitment to working with prisoners (men and women), including experience with a transitional program at Dillwynia Correctional Centre nine years ago, which was defunded. In contrast, the two Medicare Locals have a broader care coordination focus with limited service provision in this specific area.



Table 1. Organisational and spatial characteristics of the three sites

	Western Sydney	Geraldton	Townsville
State	New South Wales	Western Australia	Queensland
ML/AMS Setting	Urban	Regional city	Regional city
Population	1,315,253	62,956	421,859
Indigenous population representation in the RHCCC service area³	21,333 (1.6%)	6,663 (10.6%)	22,420 (5.8%)
Correctional Centres feeding in & women population	3 (Silverwater Women's Correctional Centre, Dillwynia Correctional Centre and Emu Plains Correctional Centre) 725 women state-wide** ⁴ (26.2% Aboriginal and Torres Strait Islander)	1 (Greenough Regional Prison) 69 (95% Aboriginal)	1 (Townsville Women's Correctional Centre) 154 (65% Aboriginal and Torres Strait Islander)
ML/AMS remoteness	Urban, rural	Regional, rural, remote	Regional, rural, remote
Regions (and LHDs) covered	Outer western Sydney and Blue Mountains (WSLHD & NBMLHD)	Midwest WA (Gascoyne, Geraldton, Midwest and Murchison LHDs)	North, Far North, Cape York, Gulf, Mt Isa, Torres Strait
Catchment size of the RHCCC service	3,302 km ²	811,134 km ²	239,180 km ²

For the RHCCC project, in Geraldton, GMLL employed a part-time project coordinator and built on their existing relationship with GRAMS who then employed a full-time worker for the project. GRAMS also has a long-standing commitment to working with prisoners, and was already providing two Aboriginal Health Workers to deliver a Re-entry program at Greenough Regional Prison. TMML-RHCCC developed a close working relationship within the prison with Bindal Sharks United Sports and Recreation Aboriginal Corporation. The main working connection between TMML-RHCCC and their local AMS, Townsville Aboriginal and Islander Health Service (TAIHS), was through referral pathways. TMML's Indigenous Advisor Program Manager had previously worked as an educational officer in Townsville Women's Correctional Centre and had already begun to progress TMML's work there and was keen to do more.

³ Australian Bureau of Statistics 2011 Census Community profiles, Aboriginal and Torres Strait Islander Peoples (Indigenous) profile, <http://www.abs.gov.au/websitedbs/censushome.nsf/home/communityprofiles?opendocument&navpos=230>, accessed 1 September 2014.

⁴ Total female adult offenders population managed by CSNSW, including 5 female only units, 2 transitional centres and 1 residential facility, in addition to the 3 correctional centres.



Another clear difference at the service level was the number of prisons feeding into the catchment of the RHCCC host organisation. For Townsville and Geraldton Medicare Locals there was only one prison, but women returned home to AMS Western Sydney's catchment from three separate institutions. The complications of developing and nurturing three sets of working relationships, with both women, and prison management and workforce, was clearly demanding.

Additionally, while all sites faced challenges in terms of the needs of women returning to locations outside of their immediate service areas, the enormous geographical area where women return home to from Geraldton (over 800,000 km²) and the need for TMML to ensure culturally safe and effective support for Torres Strait Islander as well as Aboriginal women, posed significant setting specific considerations. These included the dearth of health and social services, housing and employment opportunities in these remote areas and vast travel distances.

These descriptions only begin to highlight how diverse the service landscape is across Australia. The following recommendation is made to encourage recognition of this and the need to ensure programs on the ground are able to have a substantial voice in the planning of funding schemes to design and deliver programs.

Recommendation :

1. Funding schemes need to be mindful of the enormous diversity of settings and operate with flexibility and responsiveness to local knowledge and voices in the design and delivery of policy and programs.

B. Barriers and Enablers at the Structural Level

In addition to the diversity between host organisations, there were some common barriers faced by all three teams that impacted their operation differently. These were, influenced by variation in starting points, available resources, strategies and processes used to meet the needs of the project.

Short-term Pilot Project Approach

All sites expressed concern at the outset, which grew to reality at the end of the project, that this was a pilot with an extremely short time frame without any assurance of further funding regardless of outcome. This is a common experience



for Aboriginal programs and service providers and has become one of the major frustrations of services and communities alike.

There are many negative impacts associated with tight timeframes and pilot approaches, especially with projects that are both sensitive and complex. Three that particularly impacted the RHCCC teams include:

- Having a very tight time frame to conduct the needs assessment, develop the proposal and identify the envisioned activities: This prevented a proper consultation process to occur with the community and key stakeholders to enable broader and respectful engagement, commitment and coordination and limit the quality and innovation that often comes from multiple ideas and careful review of existing data to inform the project. This was acutely felt by all three sites with varying consequences.
- Not having sufficient time to undertake the preparatory and relationship-building work before implementation. This had serious consequences at two of the sites. For GMLL, the 12-month period was far too short for a setting that had limited experience in post-release care and service coordination and limited pre-established partnerships. Despite the vast experience of AMSWS in this area, specific issues prevented its ability to enter and operate effectively in the prison for most of the project time period (see below) due to clearance delays.
- Subjecting the team, the participants in the program and the community to the emotional loss of a proven and valued program: While TMML was able to get a comprehensive program up and running in the short time period and engage 126 women in a multi-pronged empowerment and case management experience, their funding to continue the program was terminated at the end of the pilot. As this occurred before the evaluation reports were due, there was no apparent consideration of the quality and capacity of the program in the decision for funds not to be provided to enable continuity.

Recommendation :

2. Quality programs in this crucially important and sensitive area should be properly resourced on a continuous basis, avoiding pilot or short term programs with no assurance of continuity.



Building Relationships and Partnerships

With Corrective Services

All sites found that relationships between the RHCCC teams and the Correctional Centre management, staff and program managers were a major determinant of success or stagnation. All experienced challenges with this from the beginning, as there appeared to be a lack of communication at the policy level between the Commonwealth Department of Health and the state Department of Corrections, leading to a lack of knowledge and pre-existing commitment to the Centre leadership at each site for the program to be a success.

The RHCCC teams therefore had to make their own way into the Centres, 'sell' the benefits of the program and the value of a health focus in throughcare and seek support, cooperation and permission to work within the Centre. Following these initial support-seeking activities, the teams then had to establish positive working relationships with Program managers and custodial staff which their programs relied on.

While all three programs faced this shared stumbling block, things progressed in different ways at each site. The AMSWS Back to Community team engaged with the Aboriginal Support Unit at the three Correctional Centres and enjoyed substantial early success in their activities. An initial recruitment of 12 women into the program through the Cultural officers formed a strong starting point for the team. However, for unclear reasons, permission to enter was withdrawn and access at all three Centres as community visitors was stopped. The team awaited clearance for the Back to Community Project Officer to re-commence, however it never occurred, effectively shutting down the capacity of the AMSWS team to deliver any pre-release activities with the women. Despite many calls and requests, until the completion of the project, clearance never came through.

GMML's experience was not dissimilar to that of AMSWS, with a long waiting period for clearance for the Project Officer to enter and commence case management work. This changed over the course of the project however, with a change in senior management at the Correctional Centre resulting in greater attention to female prisoners' needs and support for corrections staff and others working in this area.

The progress of events for TMML was completely different, once the Correctional Centre Management understood what the RHCCC team was trying to achieve. Progress was greatly facilitated by the team's linkage and contractual arrangement to support continuation of delivery of the highly respected Bindal



Leadership Program by a local Elder/Community Leader. The great benefits of this program had already been demonstrated to Centre management who saw the potential to build on the gains the women were making. Clearance and safety induction training for both RHCCC staff was granted within two months of application. Some cultural and gender barriers (all of the Aboriginal Cultural Support Officers were men), and misunderstanding the role of the team by Program and custodial staff were faced, but were largely overcome by persistence and constant information sharing to show mutual benefit. Another important promoter of positive relationships with Centre staff was the decision that all activities would be open to both Indigenous and non-Indigenous women.

All sites faced difficulties in gaining systematic access to court, release dates and court outcomes that were not overcome, which limited opportunities to plan and provide support at these critically important times.

With other stakeholder services

Also of enormous importance, and a point of diversity among the three pilot project teams, was the level of stakeholder engagement in enabling multi-sectoral service planning and coordination for post-release care.

At the outset of project, and facilitated by their experience with the SPRINT project, AMSWS Managers had already created an extensive network of service providers prepared to participate in a coordinated referral system to support clients coming into the Back to Community program. These included the Justice Health, Forensic Mental Health Network and Legal Aid among many others.

While these external service provider relationships are clearly important, the strength of the AMSWS itself, as a family-centred, wholistic and multifaceted health and wellbeing service, is that it offers a culturally secure and sensitive array of care pathways that can also support effective referrals to the relative abundance of social, housing and employment services in the urban setting.

That being said, solutions to these issues – i.e. due to severe shortage and costliness of accommodation, securing adequate housing and employment, remain enormous stumbling blocks for enabling women to settle and begin to address their other needs. Furthermore, AMSWS faces many challenges in helping some of their service partners recognise and improve existing pathways that are not working well in meeting the needs of Aboriginal clients.

GMML, a relatively new organisation, with responsibility for covering a huge area (54.4% of WA), experienced the maximum challenge in identifying and then developing partnerships with other organisations with a role to play in RHCCC. It took time to build a foundation for inter-agency cooperation between groups



that had limited history of collaborating (even communicating) with each other. The GMLL RH Coordinator essentially had to start from scratch, establishing connections, bringing people together in meetings and helping them recognise the value of working in partnership. Substantial achievements were made in gaining an understanding of the nature and range of services available, including eligibility criteria and referral pathways, and in developing new opportunities for care coordination. These were mainly confined to services working in Geraldton.

TMML was also a relatively new organisation, but its managers and workers brought extensive service linkage experience, as well as a wealth of informal networks through family, community and previous work. This experience had already built confidence in the staff that made communication and willingness to be persistent easier. Experience also enhanced awareness of the importance of formalising referral pathways and detailing roles and responsibilities among all parties to ensure success, sustainability and cultural security for the women. Hence TMML-RHCCC placed enormous effort on drafting and signing Memoranda of Understanding with key service providers with significant success.

This same process of communication about what services had to offer, discussing the most appropriate referral pathways and drafting and signing MOUs was beginning to be used by TMML with services located outside of Townsville, including in remote communities. This work was facilitated by the Close the Gap team at TMML that was already working across many of these areas.

TMML-RHCCC staff found that once these MOUs had been signed off by management, referrals could be made with greater confidence and the two-way communication channels this created were often very helpful. Their Yarning Circles (described below) firmly bolstered interest and enthusiasm among their service partners to become formally engaged in the RHCCC program. Levels of appreciation, respect, engagement and recognition of the team and its capacity, skill and understanding of what is needed was high among stakeholders.

The AMSWS team also identified MOUs as being essential in providing a transparent way of actually engaging, establishing agreed-upon rules of engagement between the services, and reducing the risk of constant changing of ways of rules and processes. Overall MOUs were helpful, but not always sufficient in helping keep service relationships working and improving.



Key Learnings and recommendations at structural level

In summary, all three sites experienced barriers in building relationships and partnerships that resulted from inadequate communication, acceptance, commitment, shared goals and accountability and coordination at the top levels between the Department of Health, Corrections and all relevant Departments providing post-release services. This system-level challenge not only hampered women's routine post-release success, but it also proved enormously challenging for this time-bound pilot project seeking to go beyond usual care. Waiting for clearance to enter the correctional centres was particularly disheartening and interrupted progress enormously at two of the three sites.

Policy gaps and lack of cohesive measures of accountability across other post-release services led to further difficulties in achieving comprehensive post-release planning. Safe and appropriate housing was highlighted as a particularly difficult challenge and viewed as a fundamental first step, particularly in the urban setting.

While these policy gaps were overcome locally by goodwill in local leadership and persistence and determination by the RHCCC teams to varying extents, the need for all parties to start with clear direction, guidance and expectation of better outcomes for the women from the top cannot be overstated. Shared accountability for these better outcomes by all parties and formalisation of roles and responsibilities will ensure that this becomes an expectation of ongoing routine services, not only during project lifetimes. Otherwise time, resources and energy will be unnecessarily lost and success restricted or even prevented completely due to apparent absence of good will.

To address these issues, we make the following recommendations:

Recommendation :

- 3.** Establish a high level alliance across departments to address these challenges, start multi-sector projects at a high level, getting buy in and shared goals and accountabilities across all stakeholders
- 4.** Establish and maintain avenues for shared accountability at all levels and ensure that essential information, e.g. providing dates of discharge and court hearings, are known to supporting stakeholders
- 5.** Adopt a can do, not a can't do attitude. Address entrenched can't do attitudes at all levels in the system by formalising clear roles, responsibilities and expectations with performance monitoring



C. Organisational level barriers, enablers and solutions

Many organisational challenges were experienced across the three sites and led to recognition of key principles that promoted and accelerated success if in place, and, conversely, led to time and energy loss when not in place. Five of these are described below, and recommendations are provided to assist program development.

1. Capable and connected senior Aboriginal managers need to be directly and influentially involved in funding processes, proposal development, recruitment criteria and selection, and decision-making from the beginning.

The case studies illuminated the importance of ensuring that senior Aboriginal managers are informed of initiatives right from the beginning. Aboriginal input is needed from the receipt of the funding invitation about how it is communicated to staff within the organisation, who handles the decision-making process, what community engagement processes occur before the decisions and approach are determined, who determines the selection criteria for staff recruitment that is required for success in the project and who takes responsibility for meeting the expectations of both community and the funder.

AMS Western Sydney had been working hard to provide in reach services to the three local prisons since the 1990s (nearly 25 years); putting in submissions, being overlooked or seriously under-funded relative to cost and need, hence providing services without funding. AMSWS played a crucial role in the SPRINT research project that prompted the RHCCC initiative, because it provided an opportunity to gain the evidence needed to seek appropriate resources to develop and provide effective in-reach and post-release services. Hence, although AMSWS managers were very happy to learn that Western Sydney was a chosen site for the project, it was highly disappointing for them to see funding to be offered first and given to the Medicare Local who had little experience and were not Aboriginal community-controlled. Fortunately the sub-contracting of the project from Western Sydney Medicare Local to AMSWS occurred smoothly. This enabled the senior Aboriginal manager at AMSWS to prepare the proposal and conduct the needs assessment. It also allowed the team to quickly commence work that synergised with their previous work in the setting – getting off to a strong start with the enrollment of 12 women. This encouraging start was sadly curtailed by withdrawal of the team's access.

For the other two sites, selection by DoH to take part in RHCCC was seen as a complement to their capacity to deliver; being the direct recipients gave a sense of ownership, achievement and recognition – a positive, rather than negative, starting point.



In Geraldton, after the initial proposal writing and needs assessment and service mapping stage, GMML recognised the need to build on their relationship with GRAMS, and worked to achieve this. The employment of the RHCCC worker by GRAMS, provided a genuine sense of ownership by the AMS from that point on.

Fortunately for the Townsville site, TMML had a senior Aboriginal Advisor Programs Manager already in place and managing a successful Close the Gap initiative within the organisation. Once the invitation from DoH to host the RHCCC program was received, the CEO quickly organised a meeting with the Aboriginal Advisor Programs Manager to discuss whether it was feasible or not to take on the project and, if so, to task her with shaping the program and taking the necessary steps to put it in place. The Manager recognised from the very beginning that the extremely tight time frame and complexities of the RHCCC tasks led to the selection of a Coordinator with extensive networks and strong cultural brokerage skills.

Later in the project, a second senior Aboriginal manager, who sat on the Board of the TMML, was able to further facilitate the Aboriginal leadership, highly supportive mentoring-style management, recruitment of both project staff, and the conduct of RHCCC.

2. Leadership and implementation of programs by Aboriginal and Torres Strait Islander people or by fully accepted non-Indigenous people is essential for ensuring cultural safety and effective care.

Aboriginal culture operates on ways of working that are profoundly different than those which underpin Australian mainstream systems. To recognise what is means to provide wholistic support capable of addressing the needs of this highly vulnerable and disadvantaged group, a cultural lens and an acceptance of different ways of working is required. Aboriginal and Torres Strait Islander people, or if not available, non-Indigenous persons who are recognised as understanding how to work safely and effectively with Aboriginal people, are best placed to provide programs that underpin cultural safety, engagement, change processes and enhancement of social and emotional wellbeing. If the complexities of relationships, structures and difference are not addressed, or at least respected, in ways of working, programs, individuals and communities can potentially cause harm to already vulnerable individuals.

The three RHCCC programs fortunately had access to excellent Aboriginal staff and/or non-Indigenous staff who were well accepted by the Aboriginal community. There were many examples provided that demonstrated the importance of this and no examples of this not being met within the program. However, each case study revealed descriptions of how many women sought the



opportunity to work with the team, but would not engage with workers operating within mainstream frameworks only or without cultural sensitivity or understanding.

Although there was restricted opportunity for the AMSWS Back to Community team to demonstrate this because of the withdrawal of entry, the team was directly aware of the consequences of culturally inappropriate service provision and workers who were not culturally competent.

In GMML, substantial progress was made in the last four months of the project as a result of the side by side work carried out by the well-accepted non-Indigenous Coordinator and the Project Officer based at GRAMS.

The Townsville case study demonstrated that because of the high calibre of Aboriginal and Torres Strait Islander staff leading the program, the most culturally informed approaches were taken. For example: 1) connection to community occurred appropriately, 2) both informal and formal networks were rapidly brought in as strengthening resources, 3) understanding of the community and cultural challenges faced by participants was already in place, and 4) the team employed non-judgmental and empowering empathetic (rather than sympathetic and rescuing) approaches in their work. As explained, the 'right way', i.e. cultural ways, of doing things with women that enables them to be empowered through their participation, came naturally to the TMML-RHCCC team. Their Aboriginal managers recognised, protected and nurtured the people and spaces that allowed this to happen.

3. A diversity of skills, experience and personal qualities mix of the team is needed to address the diversity of challenges faced by women returning home from prison and by programs working in this complex environment.

While Aboriginal heritage or deep respect of Aboriginal culture was an essential starting point for staff, the skills, experience and personal quality mix of the team members was also very important. The three case studies provided many examples of how this diverse mix played an important role in covering the wide range of challenges and needs that referrals required.

The AMSWS program was led by a highly respected and well-qualified Aboriginal woman with strong Aboriginal community connections, both locally and across NSW, and "a passion for women in corrections and families. Her community links and established credibility were critical to the role. Her skills and experience as a senior Aboriginal Health Worker, including care worker experience with drug and alcohol patients, and maturity were also important qualities. In the position, she performed a diverse range of direct care duties, including assessment,



referral to health and other services and ongoing case management, in addition to necessary liaison and coordination with internal and external stakeholders.

In Geraldton, the diverse skills and capabilities brought to the program by the Returning Home Coordinator role and the Returning Home Social Worker were highly complementary and essential to the direction the program took and its achievements. The GMML and GRAMS Chief Executive Officers both considered recruitment of the right people was critical to the project's success. Once appointed, the Returning Home Coordinator and Social Worker both had a major impact on its direction and shape.

The GMML RH Project Coordinator carried out substantial development work which included assessing client needs and service gaps, bringing stakeholders together and facilitating communication. Her skills and experience as a community nurse, researcher and project officer, combined with her commitment to the project was highly beneficial.

In the last four months, the GMML Project Social Worker provided direct client care (assessment, counselling, coaching, referral to health and other services and case management); outreach and community visits, often with other service providers; stakeholder engagement; and individual and community advocacy. Her culturally-sensitive and caring approach is demonstrated in the time she took in building rapport with the women and exploring their immediate and longer-term goals.

Each member of the Townsville RHCCC team and their managers brought outstanding and diverse skills and capacities and harmonised these in their work towards a common shared goal of better outcomes for the women. These included managerial, organisational and funds seeking skills, expertise in prison settings, health, social services and youth work. Cultural competency, Aboriginal ways of working and high level people skills were embedded within these demonstrated skill sets throughout the activities of TMML-RHCCC. This breadth of expertise facilitated effective working relationships across the multiple sectors involved and in the one-on-one support and group activities of the women.

4. Community engagement from the beginning is crucial for setting in place an optimal support program able to meet the wholistic and cultural needs of the women to equip them on their challenging journeys back to their communities.

AMSWS is a community-controlled organisation, governed by a local Board elected by the local community – hence it 'is the community'. Engagement processes with community residents occur in all of its service pathways,



delivery, and program development and implementation. The potential for referrals to the wide array of the AMSs highly relevant programs – from mothers and babies programs to social and emotional wellbeing and mental health care to housing support – would have provided excellent support to women returning home to Western Sydney and Blue Mountains catchment region. The withdrawal of permission to work within the three correctional centres represents a serious opportunity loss.

In Townsville, prior to moving ahead on the RHCCC funding request from Department of Health, the TMML manager proceeded directly to discuss the feasibility and receive insights offered by a highly respected Traditional Owner and Elder, who had already begun working in the setting. This respectful working relationship continued throughout the whole project, manifested through continuous cultural mentorship, wise guidance and advice, respect, alignment of goals with community vision and direct integration of the Leadership Program as an entryway into case management support and the Yarning Circles. Hence this first community engagement step leveraged major benefits to TMML-RHCCC throughout the whole project.

5. Formal and informal networks and cultural brokerage skills are crucial.

The AMSWS team possessed enormous formal and informal networks and cultural brokerage skills that made them ideal for the development and implementation of the Back to Community program. Once again, unfortunately, the revocation of permission to work within the Centres to develop and implement their case planning activities with women prevented them from utilising these networks.

The engagement of the full-time Social Worker employed by GRAMS in the last four months of the project greatly boosted the capacity of the GMML/GRAMS collaboration. That worker brought with them, in addition to a unique skill set, a host of personal, professional and community relationships that contributed enormously to the achievements realised in a relatively short time.

As mentioned above, Indigenous Advisor Programs Manager at TMML championed the selection of a Coordinator who already had extensive networks with both the Aboriginal and Torres Strait Islander community and formal services – as well as strong cultural brokerage skills to connect, engage and build on these networks even further. The rapid and extensive achievements of the young RHCCC program demonstrated the valuable role this played in all activities. Multiple examples were provided of how telephone calls to friends, family and services in other towns turned potential crises for women post-



release into positive experience and affirmations of caring from within their community.

In summary, it is clear that organisational contexts, especially with regard to the direction, guidance, leadership and delivery of the program by Aboriginal people, or by fully accepted non-Indigenous people, and community connection are extremely important. As availability of trained and skilled staff will vary markedly by location each location will need to determine how they can best implement programs appropriately to their contexts. The recommendations here are a general, not a prescriptive guide, to assist programs to take the right track by being embedded in the community and maximizing local opportunities for both formal and informal support.

Recommendations :

7. Understand that experienced, skilled and empowered Aboriginal people working on the ground will know what to do and how to do it
8. Value formal and informal networks that Aboriginal and Torres Strait Islander managers and health workers bring, their previous successes and their knowledge of sustainability in decision making

D. Program level opportunities: creating and maintaining an effective model of care

As discussed above, the three teams were being held back by many barriers at structural and organisational levels, some of which were avoided altogether creating enablers, some that were faced but overcome and others which continued to stand in the way of implementation of care planning and coordination assistance. The evaluation of the three case studies nevertheless gained substantial learning about what works in providing effective care to help the women negotiate the enormous challenges of returning back to their communities. These learnings come not only from what was achieved, but also what the teams had intended to do if the structural and organisational barriers not prevented realisation of their full potential.

1. Identifying Aboriginal values in the overarching principles of care

All three sites adopted basic principles that embody Aboriginal values in their overarching principles of care and emphasised empowerment and access – for example,

- AMSWS identified their aim was to provide care through a culturally appropriate wholistic approach, emphasising “empowerment, assistance



and access”, and offering facilitated access to a community governed health service seeking to “improve the physical, social, emotional, cultural and spiritual wellbeing of Aboriginal people” and a wide network of additional essential service providers. Their work was in an organisational context which valued wholistic care, self-determination, collaboration, and recognition of history of trauma and loss, racism and stigma, human rights, kinship, diversity and quality care,

- GMLL sought to establish a program using a culturally-appropriate, wholistic and strengths-based approach, with inter-agency and multi-sectoral collaboration, and community-based health and social interventions focused on family and peer support, and
- TMML-RHCCC achieved the implementation of a culturally-appropriate, wholistic and strengths-based approach, firmly resting on relationship building and the empowerment of women through leadership training and service brokerage as a key starting point with extensive inter-agency and multi-sectoral support.

A vast amount of work in Australia has validated these principles as essential for effective Aboriginal health care.

2. Engaging with women at optimum times to commence throughcare support.

While the ‘optimal time’ varied by place, each Program identified the need to engage as early as possible with the women to allow for ample time to develop relationships, which formed the basis of both supportive and effective planning. This was in a large part determined by the Corrections/Returning Home Back to Community relationship; as previously stated the extent of access to the women and flexibility in activities varied considerably.

For TMML, the most effective engagement occurred during and/or after participation in the Bindal Leadership Program initially, but later referrals followed the highly engaging Yarning Circles with service providers and from women encouraging each other to contact the team. TMML tried but did not succeed in gaining routine access to information on women going through court, either for sentencing or parole, hence that point of contact was less effective than through contact inside.

GMLL experienced delays in being cleared to enter the prison, so in order to begin providing support, connections were made with women during the court procedures prior to sentencing (through referrals from GRAMS, the local AMS) and entry to as well as following release from prison (see Case Studies, GMLL Report, Appendix 1). This revealed that working and being present prior to court



sentencing allowed the Returning Home worker to assist women to assemble sources of support to submit for consideration in court regarding sentencing. It also provided important opportunities for the RHCCC team to meet face-to-face and build trust with the family that naturally lead to a facilitating role in communication and connection while the women was serving the sentence, and in better informed planning for her return to the family. The Post-release support activities enabled the team to connect with women and support them through the early challenges of accessing health care and other essential services.

Another example of the important outcome of this point of engagement was identified by AMSWS, with its role being both broader and local advocacy for Aboriginal people as well as a service provider. The broader role was seen as promoting policy for better outcomes for Aboriginal people in the justice system generally through the peak body, NACCHO (National Aboriginal Community-Controlled Health Organisations) and in NSW. Their potential local role in influencing sentencing conditions was seen as enhancing mutual understanding of the process itself to the woman and the circumstances of the woman to the magistrate. An additional benefit of involvement at pre-sentencing was being seen as an advocate by the women to help initiate the relationship once inside. AMSWS also recognised the critical importance of working with the women in post-release planning wherever possible, and playing a linkage role by having the same person conducting care coordination activity inside and, upon release, facilitating access into the integrated model of care provided at the Aboriginal Medical Service.

3. Creating safe spaces for women to share their emotional burden.

Attaining a sense of calm is an important pre-requisite of clear thinking and planning. Teams from the three sites discussed how emotionally trying it can be for women to be in prison and away from their children and families, however, thoughts of returning back home to their communities and former situations can cause even more anxiety and fear as their release date approaches. The group and one-on-one care coordination experiences made possible through the program at all three sites served as an opportunity for the women to express their feelings, feel accepted and not judged and be supported as an individual with agency, potential and dignity. The Bindal Leadership Program delivered through TMML-RHCCC, while not directly focused on dealing with problems of individual women, sought to assist women to gain skills to deal with their emotional turmoil and find greater calmness, despite the chaos around them.

The importance of safe spaces as crucial for coming to terms with painful emotions and gaining the capacity to create change is evidenced by the success



of the one-on-one sessions between women and the RHCCC programs that occurred to varying extent at all sites. Each case study described the critical importance of the special relationship that developed between the women and the teams that was different from that generated in usual care models and service providers and was facilitated by Aboriginality. Relationships based on Aboriginal values of respect, reciprocity, equality, survival and protection and responsibility have assisted Aboriginal people for tens of thousands of years - and it is possible that for many Aboriginal and Torres Strait Islander women in custody, the opportunity to experience the calming and personal growth that a high quality relationship with the RHCCC teams that embedded these values may have been a unique starting point for real change.

4. Facilitating access to Aboriginal healing and leadership programs inside.

While not available at all sites, and rarely demonstrated in the evaluation literature, the Townsville experience highlighted the great benefit of enabling access of women to the Bindal Leadership Program to help them recognise their strengths and capacity and gain skills to help overcome their burden of pain from past trauma. The extent of these burdens, and their impact on mental health, and alcohol and drug use cannot be overstated, but is unfortunately without a substantial evidence base at present. Programs that assist in healing and empowerment, although highly under-researched in this setting, can support significant life transformation among some participants. This not only promotes a sense of calmness and enhances practical skills for change, they may also assist in healing from past pain, gaining voice, changing one's vision of their own capacity and potential future, avoiding pitfalls that had pulled them back previously and becoming strong in redirecting their lives in a positive way.

In Townsville, the one-on-one support and tailored assistance in planning and connection with services provided directly by the TMML-RHCCC team was seen by stakeholders to sustain and direct the gains women received through the Bindal Leadership Program into clear actions they could take once released. The evaluation DVD produced by TMML-RHCCC during a post-release campfire meeting provide moving narratives of healing and transformational change experienced by three women.

The AMSWS team discussed in the interviews an example of peer support that had developed within the men's prison, facilitating caring and positive role modeling inside. While potentially positive, it is important that this is done carefully, ensuring that emerging leaders are protected from lateral violence, jealousy and resentment.



5. Managing eligibility issues and inclusive versus limited access

All sites also expressed challenges with determining eligibility criteria for participation in RHCCC activities between Aboriginal and Torres Strait Islander women and non-Indigenous women, as well as among women of different 'status' within the prison system. All recognised the danger of excluding non-Indigenous women and fostering a sense of anger in not having access to similar services, and equally, disappointment and sadness in not having the opportunity to engage in something that would very likely benefit all women.

The question of eligibility was most directly faced in Townsville, and a firm decision was made, adopting the approach used by the Bindal Leadership Program in its previous two programs in the Townsville Women's Correctional Centre that all women, i.e. both Indigenous and non-Indigenous, would be welcome to all components of the RHCCC program. The interviews revealed that this not only promoted a sense of fairness and equality that made the women feel good generally, it was also highly appreciated by multiple levels of the Centre's staff – from management to the workers directly involved. In practical terms, only a limited number of non-Indigenous women did become participants in the various activities offered by RHCCC, so this did not over-burden the time available for the team for case management activities.

In further spirit of inclusion, the Townsville Women's Correctional Centre management took highly proactive steps to allow access to the Bindal Leadership Program and the Yarning Circles (described below) by women on remand but not yet sentenced, those on short sentences and all others who were normally excluded from prison programs. The Centre also sought and gained "criminogenic status" for the Bindal Leadership Program, meaning that the Centre was required to offer it within their suite of regular programs to all women.

Furthermore, because of the positive reports from the women, the Townsville Men's Correctional Centre, located adjacent to the Women's Centre, facilitated the running of the Bindal Leadership Program, and involved the RHCCC team in its delivery, for the men with great success.

Hence this example highlights the unexpected benefits gained through an inclusive approach that started between Indigenous and non-Indigenous women, widened to include access to all women, increased its partial sustainability through the system and then extended beyond to the neighbouring men. It also illustrates a can-do attitude and the outcomes that can result from a spirit of true cooperation between Corrections, a community leadership organisation and a health organisation.



6. Facilitating group involvement of family members and friends on the outside

The experiences of women while in prison and also in their return to community impact, not only on the women themselves, but also on their families and friends who may be experiencing intense emotional distress at their absence from everyday life. Not understanding why they are incarcerated and not being able to take part in the wellbeing of their loved one can cause feelings of helplessness, frustration, anger, confusion, resentment, uncertainty and confusion, as well as anxiousness about their wellbeing while inside. This array of painful emotions, if left unsupported, can promote loss of mental health and difficulty in facing the person upon release, particularly among the children of women in prison. Although none of the RHCCC programs were able in the short time available to create mechanisms, such as an informal carers support group, to help promote agency and planning among families outside through communication with the women while in prison, the idea was discussed with AMSWS who had witnessed the effectiveness of an informal carers group that had previously operated. An AMS would be an ideal place to host such an activity as a family-centred community-controlled service provider and entirely consistent with their wholistic model of health care. The high rates of incarceration within the Aboriginal population leaves many families in the community in need of opportunities to talk about their feelings, work through them and take caring action with others. This has multi-way benefits to all parties and the community as a whole.

7. Promoting confidence and voice in service provider interactions to facilitate positive choice, reduces access difficulty and add value.

As mentioned previously, the role of care coordination/case management by the RHCCC teams was seen to be highly beneficial in a multitude of ways. The one-on-one consultations allowed women to be heard, as an individual, and receive support based on their strengths, potential and challenges. The many narratives of women receiving support through RHCCC, whether pre-sentencing, while inside, prior to departure or post-release, highlight the power of relationship building, facilitation of the complex and difficult process of reintegration, enhancing likelihood of accessing effective services and staying on their feet.

A parallel role of RHCCC was in building bridges between service providers and the women. Facilitating communication, enabling success and being a constant reminder of the importance of their work was a strategy used by TMML to bring many service providers into referral relationships underpinned by sign and adopted MOUs.



The case management/care coordination referrals conducted with the Townsville Women's Correctional Centre allowed for a range of activities to occur. These included informal sharing to allow the RHCCC team to assess how well the woman was doing and build rapport. In the initial visit, a referral form identifying needs for support, a form to register for a Personally Controlled Electronic Health Record (eHealth), and consent forms were completed. Follow up visits included interviews to create Holistic Transition Pre and Post Release Plans and Action sheets based on the Holistic Transition Plans to list the needs and actions that are required to address them. The RHCCC team then worked with services to facilitate the fulfillment of the actions with the woman, both pre- and post-release. The enrollment of 126 women in these referral processes, often occurring in multiple visits is clear evidence of their value to the women.

The evaluators were able to witness an innovation at Townsville called the Yarning Circles that enabled women, as a group, to assume an empowered position in finding out what services could offer them once they were released. Their own post-release plans assisted them in making the connections they wanted across the service spectrum, helping them be pro-active in voicing their needs and influencing how the service would assist them to meet those needs. These Yarning Circles proved very popular with the women, the Correctional Centre and the service providers – with multiway benefits to all parties.

8. Measuring, acknowledging and celebrating achievements to further cement gains

Special arrangements to acknowledge women's achievements through their stay and after returning home are likely to be remembered and cherished by the women to help them continue on a positive pathway in their lives, despite many challenges they will need to negotiate in their return home. While the RHCCC had a brief lifetime from commencement to the ceasing of funding, there were opportunities for women to tell their stories and celebrate their achievements. TMML-RHCCC organised a series of graduations for women who completed the Bindal Leadership Program and a post-release campfire meeting for women to share and acknowledge each other's success.

TMML-RHCCC also established a number of mechanisms with which to embed in a continuous quality improvement framework and demonstrate their achievements across several areas of the program. They exceeded accountability requirements in this project and sought to put in place both qualitative and quantitative mechanisms to capture progress, program quality and outcomes.

Examples of mechanisms they had already employed:



- Measuring the success of the Yarning Circles, in attendance, active participation and in counting immediate and subsequent referrals to the case management activities that occurred
- Documentation of the referrals and actions taken to meet the discussed needs of the women
- Demonstrating numbers of women moving into the program from the various entry points
- Capturing the stories of life changes recounted by the Project staff
- Documenting the testimonies of the three women's post-release journeys on the DVD

GMLL commenced collection of the case studies which were included in their Case Study report to identify the many important ways that the team had supported the women, pre-sentencing and following release from prison.

Summary

Evaluation will be a very important component of future delivery of the Returning Home Back to Community from Custodial Care project, or any further implementation of the learnings from this initiative. The following chapter synthesises the learnings achieved in the three case studies documented here, with those of the literature review (Chapter 2) and presents a considered evaluation approach for future use in planning, implementing, monitoring and evaluating throughcare programs for Aboriginal and Torres Strait Islander women.

Recommendations :

- 9.** Ensure that programs are well supported to implement mechanisms to collect appropriate data on program quality, needs assessment, process, impacts and outcomes and costs to enable demonstration of their value.



4. Metasynthesis of learnings and application to a wholistic evaluation framework

With each of the three sites' own reports and this overall report prepared by the evaluation team, we must now move ahead from the pilot project phase of *Returning Home, Back to the Community from Custodial Care* and into its envisioned second stage of broader implementation. While the pilot focused on Learning, the next phase must utilise these learnings in order to push back on the rising tide of disadvantage Aboriginal women exiting correctional centres face. The statistics clearly show that when insufficiently supported, women returning back to their communities are often overwhelmed by the challenges in meeting even their most basic needs. This perpetuates the well-known cycle of returning from prison, back to community and back to prison. This chapter aims to distill the learnings from the previous chapters to create a framework of accountability that can be used to move forward, breaking the cycle, most effectively, efficiently and sustainably.

In this chapter, we distill the study findings to create and validate an evidence-informed guide for both policy and practice planning and evaluation. We adopt an Aboriginal-developed framework to highlight the importance of operationalizing enduring principles as well as flexible delivery processes that could be applied in other settings. This chapter also emphasises the critical need for culturally informed evaluation approaches, using tools and measures that capture the important processes and outcomes required for success, including effectiveness, sustainability, resources for growth and achievement of full potential in the wider landscape. This chapter reveals how application of study learnings into post-prison release programs would not only promote success; it would also advance the application of core Aboriginal values, embodied within 'ways of doing', which are often committed to by governments in their assertions their policies and programs will be culturally appropriate.

About the Ngaa-bi-nya Framework

The cross-case analysis has extended the current literature base by providing a substantial volume of information about how appropriate care pathways can be designed, implemented and nurtured by structural and organisational supports. We note two overriding stumbling blocks in moving from pilots to permanent programs – one being high level commitment that is operationalised at subsequent levels across Departments – especially between Corrections and Health, but also among housing, social services, education and employment. The Townsville case study particularly illustrated the unique role that Health theoretically can, but at present largely doesn't, play in coordinating and



energizing other services to be part of a collective effort achieving good outcomes. Townsville's approach was wholly embedded in empowerment and social and emotional wellbeing, which many Aboriginal people (and many of our state and federal policies) recognise as fundamental underlying conditions for health, personal growth and capacity for positive change among individuals, organisations and communities. Foremost on Aboriginal people's minds are culturally-informed ways of doing, writings and discourses; this study found that non-Indigenous people, when exposed to and experienced with these, often also recognise and strive for the same.

Thus, in developing a culturally-informed and effective guide for advising and evaluating empowering models of care, it is essential to learn from the past, adhere to Aboriginal and Torres Strait Islander research principles, and build capacity of others in program development and delivery (National Health and Medical Research Council (NHMRC), 2003).

For this metasynthesis, we have chosen Ngaa-bi-nya framework as a guide because it effectively requires services to be designed in a way that identifies and attempts to respond to the social context of Aboriginal and Torres Strait Islander people's health, and as a result of social action, promotes inclusivity of Aboriginal women's experiences, rights, recourse and aspirations to participate in Australian life, with equity. Ngaa-bi-nya is a Wiradjuri verb for examine, try, evaluate (Grant and Rudder, 2010). Aboriginal people lead development of the Ngaa-bi-nya framework, with insightful, synergistic thinking for wholistic, continuous quality improvement. The framework incorporates learnings from many years of experience with Aboriginal and Torres Strait Islander health research and service delivery, and reflects on the work of Stufflebeam (2003). Importantly, this framework is flexible and responsive to diverse settings and therefore transferable to other Aboriginal and Torres Strait Islander health and social programs. The framework also aligns with Critical Success Factors developed from case studies with other Aboriginal and Torres Strait Islander health and social programs, and described below (Haswell et al, 2013).

What have we learned through this evaluation process?

Congruence between the literature and the case study findings

It was confirmed in both the literature review and in all three case studies that, far from just criminogenic factors at play among Aboriginal women in prison and at risk of recidivism, the social, geographical, and historical circumstances that Aboriginal women face pose enormous health and wellbeing challenges. Further, all data confirmed that programs for Aboriginal women must be both gender-



sensitive and culturally appropriate, Congruent with this finding is a recent review of good practice in women's corrections (Bartels and Gaffney, 2011), which found that corrections systems tend to be organised around the needs of male prisoners, with special provisions for women being 'added on'. The SPRINT project highlighted the necessity for a wholistic and integrated approach to address the health and wellbeing challenges faced by Aboriginal people going back to community from custodial care. Aboriginal women's ability to access housing, family support and health and other services are key their successful transition to community living (SPRINT Project Team 2013; Williams, 2014).

There is little doubt that the project teams were all acutely aware of, and were seeking to address, the complex challenges associated with social and historical determinants of health that impact on the everyday lives of these women. The teams sought multi-sectoral links at the management level with service providers that are needed to support women in their return back to their communities. All sought to operationalise referral mechanisms to ensure that the women were confident and supported to access the array of service providers that could help them deal with immediate and longer term needs. These included housing, contact with family and children, domestic and family violence, employment and education opportunities, and health services able to provide support for mental health problems, social and emotional wellbeing, drug and alcohol, and sexual and reproductive health care.

The case studies corroborate with the literature and program review in illustrating the critical importance of ensuring that key government departments are willing to prioritise cooperation and commitment to achieving success with the RHCCC teams, without which substantially less could be accomplished. With government departments involved, the policies and systems provided little incentive or guidance on how to work together, leaving it up to each correctional centre to determine the extent of collaboration and effort they wished to make to improve the post-release journeys of these highly disadvantaged women.

The AMSWS experience demonstrate what can happen when Corrective Services, Justice Health and Forensic Mental Health Services appeared to have little interest or capacity to engage; hence all twelve referrals were made in the first months before the team's access to conduct in-service activities in the three local correctional centres was revoked. The GMLL case study flags the positive advances that can happen when correctional centre leadership changes from one with little interest or capacity, to one that was proactively supportive. TMML-RHCCC provided an outstanding example of the potential impact that can be made through strong supportive relationships. The Townsville Women's Correctional Centre General Manager embraced the program almost from the start and facilitated the achievement of its potential – the team of two staff was



able to receive referrals and provide pre- and post-release planning and an array of other supports with 126 women. Thus waiting for clearance to enter the correctional centres essentially stopped pre-release engagement and care-planning at two RHCCC pilot sites, while at the third, clearance to enter was granted to both staff within two months, allowing them to progress rapidly and exceed expectations.

Also highlighted in the cross case analysis and in the literature was the need to take into account enormous diversity between the RHCCC sites, their models, Aboriginal community make-up and cultural perspectives.

Using Ngaa-bi-nya as an evaluation framework

The Aboriginal and Torres Strait Islander health and social services sector has often been described as under-evaluated, unsustainable and lacking in ‘evidence’ about what works and why. While many interrelated factors are at play in this, including the historical under-privileging of Aboriginal and Torres Strait Islander people’s knowledges in the criminal justice system (Cunneen and Rowe, 2014), the other practical barrier has been lack of researchers’ experience and confidence conducting evaluation, particularly without a framework sensitive to Aboriginal and Torres Strait Islander programs. The Ngaa-bi-nya evaluation framework reflects an eco-social model of health, which is crucial to promoting best outcomes (Carson et al., 2007). Specifically, the Ngaa-bi-nya evaluation framework requires of those undertaking any type of program evaluation that the broadest context, the ‘Landscape’ must be taken into account, as well as Aboriginal and Torres Strait Islander ‘Ways of working’. As explained earlier, the three case studies clearly identified structural issues at play, including barriers to the inter-sectoral collaboration required to address the multiple disadvantages experienced by Aboriginal women exiting correctional centres, but despite this being able to create safe spaces for Aboriginal women to start to address some of their needs in the transition from prison to the community.

In addition to these contextual considerations, society also has expectations that its resources are being applied to initiatives that are likely to be effective. The ‘Resources’ aspect of the Ngaa-bi-nya framework prompts policy and program designers, implementers and evaluators to record all of the inputs into interventions, including knowledges, funding, in-kind support, equipment and networks, to ascertain how programs can demonstrate their effectiveness as well as value for money. Equally important is that we use appropriate tools that measure and identify movement towards those outcomes, as well as the more tangible outputs and outcomes more often identified by evaluation. The ‘Learning’ aspect of the Ngaa-bi-nya framework values and prompts inquiry about movement and progress made in program development and

implementation; for Aboriginal and Torres Strait Islander people, the burden of socio-economic disadvantage and poor health is so complex and great that incremental progress toward change, in systems and for individuals must be identified and championed, to inform how to achieve further change. The Ngaa-bi-nya framework is excellent in reminding us of the barriers and challenges that need to be overcome before outcomes are achieved – and the learning processes and early and intermediate goals required to signal that improvements are being made, as well as a timeframe of expectations that realistically can be met. This requires and signals the need for reflexivity in program implementation, incorporated into the Ngaa-bi-nya framework as indicated by the arrows in Figure 1 below. This reflexivity is particularly relevant to piloting of new projects and programs, such as Returning Home Back to Community from Custodial Care.

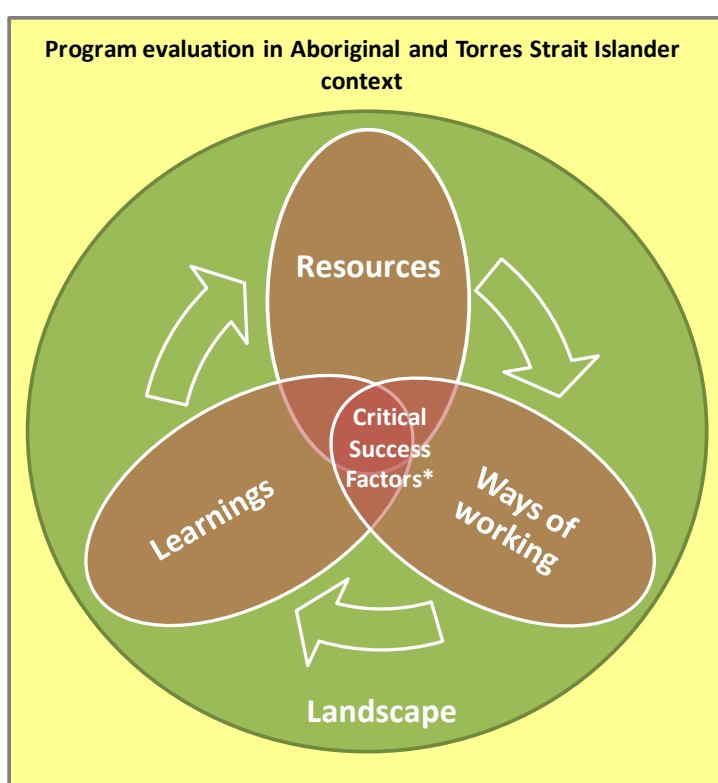


Figure 1: Ngaa-bi-nya evaluation framework

Chapter 2 introduced a summary table of the key Learnings of the Ngaa-bi-nya evaluation framework that highlight the basic principles and processes required for culturally sensitive models of care. The extent to which these principles and processes are operationalised in program processes is likely to reflect all aspects of program success, including effectiveness, sustainability, capacity to growth and achievement of full potential. The Table is reproduced below.



Table 1. Learnings: Important features of models of care

Wholistic 1	Interconnected parts - body, mind, spirit, land, environment, custom and socio-economic status
Responsibility 2	Resourcing, accountability, working with integrity and according to Aboriginal and Torres Strait Islander values, self-determination, political advocacy, continuity, sustainability, evaluation and reporting
Cultural leadership 3	Knowledge, processes, frameworks, strengthening identity and knowledge, survival and protection, cultural sensitivity, safe spaces, contextualisation
Strengths based 4	Working from positives, not deficits, celebrating achievements
Strong relationships 5	Trust, respect, equality, reciprocity, intergenerational, inter-sectoral, communication, transfer of knowledge, linkages
Community capacity building 6	Leadership, mentoring, role modelling, guidance and strategies, individual and community, planning and actioning, transferable and applicable knowledge, decision making, access to education and training
Build infrastructure 7	Planning, housing, health, employment, transport, legal, systems, resources
Progressive 8	Reflection, innovation, managing change, sustainable, over time – past, present, future, self-determination
Spirit 9	Celebration, valuing potential, large young population to support in the future – very different to mainstream Australia
Workforce development 10	Transfer of knowledge, skills, experience, Aboriginal and Torres Strait Islander Health Workers
Evidence base 11	Contribute to this, use, critique, expand on, advocate, assess transferability
Addressing determinants of health 12	Upstream, midstream and downstream



The right evaluation framework, at the right time

Evaluation is the analysis of information collected during routine monitoring or at other appropriate times for the specific purpose of *“identifying the efficiency, effectiveness and appropriateness of programs against some predetermined yardstick”* (NAHSWP 1989, p. 219). A formative evaluation is a method for judging the worth of a program while program activities are forming. A summative evaluation, on the other hand, is a method of judging the worth of a program after the activities are fully implemented (Owen & Rogers, 1999).

For new programs, it is also important that we utilise the right kind of evaluations at the right time – where necessary, moving from formative to process or program quality assessments, to impact and outcome evaluations, which ideally are fed into cost benefit and ultimately cost-effectiveness studies. Further to this, and linking with the need to understand processes and measure progress and outcomes in Aboriginal and Torres Strait Islander programs, is the choice of culturally relevant tools to ensure the measurement of the right things. Again, few frameworks or tools have been available to guide this movement, either for mainstream or Aboriginal and Torres Strait Islander programs. Few tools have been available either, to understand the extent to which the principles and values considered vital for Aboriginal and Torres Strait Islander programs (NHMRC, 2003) have been adhered to, in order to be accountable to these.

The Ngaa-bi-nya framework usefully includes at its centre ‘Critical Success Factors’, which help identify in more detail aspects of program development and delivery that meet the needs of and achieve outcomes with Aboriginal and Torres Strait Islander peoples. Figure 2 below, depicting the Critical Success Factors and borrowed from Haswell et al. (2013), exemplifies the stage of development that effective programs often go through in their evolution, from assistance to individuals towards broad improvements in population outcomes.

Applying this second framework, the Critical Success Factors, to the three Returning Home Back to Community from Custodial Care case studies, it was clear a formative evaluation was appropriate to all three. However for the Townsville program, given the multi-faceted support as well as the substantial numbers of women it demonstrated capacity to assist, a summative (or outcome) evaluation with cost benefit assessment was also recommended.

Table 2 describes the four stages or states of programs and impacts that can be expected in reach and scope given the level of program support in relation to need. It is assumed that the program or service has the capacity to be effective, adapt and grow but may be held back by resource and funding amount and security.

Table 2. Four Stages or States of Programs and impacts

YOUTH PROGRAM INTERFACE	Just Surviving	Effective but not growing	Growing effectively	Flourishing to reach full potential
DEFINITION	Able to keep up a small presence and continue doing good work despite major challenges	Able to provide, maintain and demonstrate positive impacts on a small number of youth	Working effectively and increasing in capacity and reach while maintaining effectiveness in helping youth move forward	Working well, growing in reach and scope and supported to play its full potential role in youth development
AMOUNT OF CONTACT	One off with little or no ongoing follow up, brief encounter	Longer duration of contact, e.g. overnight camps or multiple short interactions, limited chance to reach into everyday life, limited family interaction due to time constraints		Time to work with individual, peer groups, families and communities with the knowledge that this will secure permanent change
STAFF	Rudimentary staff, highly overworked, no protective buffer to cover unexpected changes, reliant on very stressed champion	Medium level of staff, stable and able to tolerate turnover but too small to meet demand or extend reach	Sufficient and empowered staff, can expand with demand but busy and restricted in capacity to consider innovative ideas for new areas	Empowered workforce, can grow with demand and be proactive in increasing impact. Workforce development mechanisms in place
RIPPLE EFFECT	Minimal ripple effect on others who may push back any long term change	Family and friends can see the change in the youths' lives, may reengage in school and set some goals	Growing numbers of families and friends can see the change in the youths' lives, reengage in school and set some goals, less likely to lose momentum	Community is able to feel and be strengthened by the change in youth, be proud and fully encourage their positive direction
DIRECT IMPACT	Youth are engaged, enjoy themselves, unique experiences they wouldn't have otherwise, may help the most severely affected out of crisis, become aware of different possibilities, get a taste of what healing is	Participants describe processes of healing, personal growth and empowerment, some will be able to describe clear translation of these changes into their life trajectory	Growing numbers experience healing, personal growth and empowerment and capacity to change life trajectory, some will not. Creates new awareness for opportunities to efficiently deliver outcomes and meet wider needs	Program is able to promote broader healing, personal growth and empowerment among a broad cohort of youth
MEASURABLE IMPACT	Not likely to be able to detect sustained impacts	Appropriate developed measures corresponding to program aims and process will detect positive outcomes for participation but not wider change	Appropriate outcome measures will detect positive outcomes on a wider number of youth participants, may see slowing of negative trends	Will observe significant change in SEWB among indigenous youth generally, and slowing, stopping and reversing negative trend
SUPPORT REQUIRED	Needs time to learn, is developing future plans and getting funding	Support leadership at multiple levels and provide nurturing support understanding constraints. Recognise local knowledge about processes and avoid stress underfunding	Recognition from upper management levels, the community, stakeholders and funders. Provide essential support for expanding reach and capacity	Provide support to reach full potential, encourage CQI mechanisms & qualitative measurement of impacts and sustainability in the long term

Why the Critical Success Factor Tools?

At the intersection of the three arms of Ngaa-bi-nya and equally embedded in the Landscape of the program are the Critical Success Factors. Previous research conducted by Muru Marri with six valued Aboriginal youth social and emotional wellbeing programs led to the identification of four sets of Critical Success Factors (Haswell et al., 2013). These factors appeared to be crucial for program effectiveness, sustainability, growth and achievement of full potential. These have since been used in many different settings and have shown their value as universal tools to assist in the identification of program strengths, quality of design and culturally safe and appropriate delivery. Used as a framework in qualitative research, these tools provide a relatively rapid mechanism to elicit in depth reflection and discussion of how well the program is doing in key areas



and what changes could be made to foster even greater achievement. As evaluation tools, they not only focus on important, but often unspoken aspects of programs, they also bring people's ideas and perspectives together in empowering ways to collectively contribute to their improvement.

Culturally-appropriate services that operate from a community base and incorporate known critical effectiveness factors for improving social and emotional wellbeing are more likely to be effective in the long-term. In the early stages, in addition to taking a strengths-based approach, these include: being patient to develop a relationship bond first, then using the relationship to move towards change; modelling reliability and consistency; facilitating connection to family, community and culture; adopting a non-judgmental approach, using mistakes as a way to build new skills for better choices; setting rules and boundaries; maximising opportunities for decision-making and self-determination; and celebrating small achievements and positive changes (Haswell et al., 2013). At the same time, the underlying issues and upstream social determinants of health must be addressed (Johnston, 1991; Davis & Brands, 2007).

Applying the Critical Success Factors for evaluation within the Ngaa-bi-nya framework for Returning Home, Back to the Community from Custodial Care

Two sets of factors assessing effectiveness and sustainability within the existing Critical Success Factors were found to align extremely well with the Ngaa-bi-nya framework and the key insights identified in the cross-case analysis and metasynthesis of the *Returning Home, Back to the Community from Custodial Care* evaluation. The two assessing factors affecting growth and achievement of potential were less directly aligned with the project's learnings, hence two new sets of factors, namely the Critical Landscape Factors and Critical Resourcing Factors, have been created to increase generalisability and clarity.

Each of these four sets of factors are briefly described below. Tables 3 through 6 demonstrate the congruence between the information generated using each of these sets of factors and the detailed cross case analysis findings presented in Chapter 3. This provides evidence of their validity and efficiency in the capture of the most relevant evaluation data on program quality, barriers, enablers and opportunities experienced at structural, resourcing, organisational and program levels. These levels are entirely compatible with concepts of Landscape, Resources, Learnings and Ways of Working within the Ngaa-bi-nya framework.

Furthermore, the level at which the Critical Success Factor items are achieved will also determine the extent to which the program is operationalising the important values embedded in culturally-informed care, i.e. the Ngaa-bi-nya



items identified in the literature review and depicted in Table 1. These items can be applied within formative, process and summative evaluations and continuous quality improvement exercises engaging teams through qualitative assessment (interview or focus group), numerical assessment (e.g. on a scale of one to ten, how are we doing?) or by new methods currently being developed by Muru Marri.

Set 1. Critical Landscape Factors (*adapted from Recommendations of this evaluation, Chapter 3*): A tool to assess the presence of broader conditions that programs operate within that facilitate or impede achievement of their full potential

Returning Home, Back to the Community from Custodial Care insights:

As discussed in Chapter 3, all three sites reported some level of barriers, with substantially varying extents, duration and impacts, faced in building relationships and partnerships that resulted from inadequate communication, acceptance, commitment, shared goals and accountability and coordination at the top levels of relevant Departments providing post-release services. Policy gaps across other post-release services were also seen to cause further difficulties in achieving comprehensive post-release planning. Safe and appropriate housing was viewed as fundamental. Many of these challenges stemmed from the lack of consistent performance indicators among the many key stakeholders and absence of client outcome measures. Without such cohesiveness, energy will be unnecessarily lost and success restricted.

For future evaluations:

The Ngaa-bi-nya framework and the 7-item Critical Landscape Factors shown on Table 3 were designed to capture the Landscape issues important to take into account in preparatory stages for successful program development.

Set 2. Critical Resourcing Factors (*adapted from Recommendations of this evaluation, Chapter 3*): A tool to assess the adequacy and security of program mechanisms, resourcing and accountability requirements that facilitate or impede their capacity to grow to meet increasing demand

Returning Home, Back to the Community from Custodial Care insights:

As discussed in Chapter 3, all sites faced serious challenges in the short time available for community consultation in the proposal development and needs assessment. While level of resourcing was not an issue, the very short duration of the pilot and the ceasing of funding caused substantial loss of investment in an area where there is enormous need and inequity of outcomes. Without continuity of support for women exiting correctional centres, rates of recidivism will remain extremely high.

For future evaluations:

The Ngaa-bi-nya framework identifies these as Resource issues. The 8-item Critical Resourcing Factors tool shown on Table 4 was designed to capture these highly important funding mechanisms and security, as well as crucial aspects of program development identified in the evaluation.

Set 3. Critical Sustainability Factors (*Using Learnings, taken directly from Haswell et al., 2013*): A tool to assess the sustainability of programs focusing on the common elements that make programs strong and resilient through difficult times

Returning Home, Back to the Community from Custodial Care insights:

The literature review and cross-case analysis identified many issues operating at organisational level that are associated with sustainability of Aboriginal programs. Highlighted here are the extent to which the program authentically embeds Aboriginal ways of doing through all activities and relationships, is sensitive to the need for staff support mechanisms, is guided by Aboriginal leaders, and is continuously evolving through reflective practices and knowledge transfer through mentoring relationships.

For future evaluations:

The Ngaa-bi-nya framework identifies these as Learnings. The 10-item Critical Sustainability Factors tool shown on Table 5 was designed to capture these highly important aspects of program strength and longevity within the community.

Set 4. Critical Effectiveness Factors (*Ways of Working, taken directly from Haswell et al., 2013*): A tool to assess the likely effectiveness of programs focusing on the common elements that enable programs to provide care that meets needs and empowers women to stay on their feet.

Returning Home, Back to the Community from Custodial Care insights:

The literature review and cross-case analysis identified a range of activities delivered with the women while attending court for sentencing, while inside the correctional centre and during and after their release from custodial care. There is good understanding of the characteristics of care that promotes effectiveness and advances cultural ways of working that keep people safe, allow them to express themselves, recognise their strengths and potential, and progress into their future with greater confidence and skills.



For future evaluations:

The Ngaa-bi-nya framework identifies these components as Ways of Working. The 9-item Critical Effectiveness Factors tool shown on Table 6 was designed to capture these highly important aspects of how to create a safe, transformational space and connect women to services that can assist them in their homeward journey that were identified in the evaluation. The level at which these items are achieved will also determine the extent to which the program is operationalising the important values embedded in culturally-informed care, i.e. the Ngaa-bi-nya items identified in the literature review and depicted in Table 1. These items can be applied through qualitative assessment (interview or focus group), through a numerical assessment or by new methods currently being developed by Muru Marri.

Summative Evaluation Measuring care pathway success

Routinely collected measures and other mechanisms to assess efficiency of care pathways and success of referrals in improving service access and outcome

The Critical Success Factors provide a guide to assessing program quality and potential. They can be used often and at any time. As described above, once a program has had time to become established and in operation, mechanisms should be put in place to monitor aspects such as participation, duration and types of interactions, key challenges raised, referrals made, satisfaction, follow up, etc. tailored for each component of the care pathway. In most circumstances, the information system used in the host organisation can be used to capture this data, often providing quick and easy displays to enable the team to frequently examine and reflect on up-to-date information on levels of engagement in their activities.

Follow up data collection, examining not just services and referrals delivered, but the impact and outcomes of these would enable a fuller recognition of the programs value.

At the service level, in addition to the total number of women engaged, summative evaluation measures should reflect the types of assistance provided. Examples include:

- housing—how many women have suitable accommodation
- health—how many women access a regular GP, how many are in counselling or have a mental health care plan
- employment—how many women gain employment
- education – how many women become enrolled in a course,



- justice - how many women have been in trouble with the law or re-incarcerated
- family—how many women have regular access to their children
- community and culture—how many women participate in community and cultural events.

At the individual level, it is important to determine the extent to which the women consider they have made progress in reaching their own goals. Personal testimonies, interviews and case studies collected on a periodic basis will provide important qualitative information. Consistent with the wholistic model of care, all case studies should consider the whole person and the combined input of the specific program and others; not just one aspect of the client experience. These activities can have multiple benefits. For example, the TMML-RHCCC team has produced their own Evaluation DVD with women who are keen to share the stories of their journeys with other women and programs, hoping that their experiences will inspire other women to move their lives forward in their own positive directions.

Measuring change in empowerment and psychosocial wellbeing, for example using the Growth and Empowerment Measure

The Growth and Empowerment Measure, nicknamed the GEM, was developed using information gathered from Aboriginal participants of effective empowerment programs (Haswell et al., 2013). It has been used in three correctional centres and a drug and alcohol residential rehabilitation program. It has been shown to provide valuable information through a positive experience, unlike many non-culturally informed, negatively oriented assessment instruments (Andersen & Heffernan, in preparation). The GEM is also highly sensitive to change facilitated by programs focused on social and emotional wellbeing and is valid and reliable for use with both Aboriginal and non-Indigenous people (Berry et al., 2012; Gaskin et al., in preparation).

Completion of the GEM aims to be part of the empowering process by encouraging people to reflect on where they currently are in light of their past, present and future possibilities. It captures important and valued changes in wellbeing and empowerment that enables people, even in difficult circumstances, to gain control over their lives and situations and work towards individual, group and community goals. It is comprised of sub-scales measuring inner peace, self-capacity, healing and growth and meaning and purpose (Haswell et al., 2010).

The *Returning Home, Back to Community from Custodial Care* pilot has stimulated the development of wholistic models of care to facilitate women's re-engagement



with their families, communities and service providers in ways that promote their capacity to move their lives forward in positive directions. These processes are consistent with those of empowerment programs that enhance healing, life skills, personal growth and social and emotional wellbeing (Tsey et al, 2007; Tsey et al., 2010; Laliberte et al., 2010). Hence the GEM, developed with Aboriginal and Torres Strait Islander people and highly sensitive to change, may be an ideal instrument to measure these subtle, but critical changes that can be fostered among women assisted empowering throughcare. It can be used with all participants of health and community projects, to capture their experience, to then combine with the service and system level insights garnered by the Ngaa-bi-nya framework and Critical Success Factors.

In summary, we have provided suggested examples of tools and processes that can guide each step of program development, delivery and evaluation. Importantly, evaluation measures should be developed in collaboration with key stakeholders, to ensure agreed meanings of terms such as 'suitable', to also assess satisfaction with quality of care and to make sure that the framework and instruments used match well with expectations and cultural perspectives of the communities and participants.

Conclusion

In reflecting on the achievements and critical successes realised in the *Returning Home, Back to Community from Custodial Care* pilot, this chapter also established useful tools that integrate with each other, to provide a comprehensive evaluation of health and social programs to improve the wellbeing of Aboriginal and Torres Strait Islander people. Too few such innovative tools have been developed or made available in light of the gross and ever-increasing over-representation of Aboriginal and Torres Strait Islander people in the criminal justice, welfare and health systems in Australia. It is an imperative that programs funded and conducted are made more accountable through evaluation, which also enables the learnings of these programs to be built on in practice and to contribute to better public policy. Evaluation is an important form of evidence, which helps establish that often what occurs in Aboriginal and Torres Strait Islander programs is culturally sensitive; evaluation is critical to ascertain options for broader and sustained implementation and coordination, with appropriate allocation of funding and resources for this to occur.



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Table 3. Critical Landscape Factors (CLFs)(modified Critical Societal Factors) associated cultural needs and values and application to the three case studies.

Critical Landscape Factors* Optimal Situations for Success	Ngaa—bi-nya Items identified in review	Importance, effort, challenges, mechanisms used to operationalize the Critical Factor in care pathways for women in Returning Home Back to Community
CLF1. There is a functional, high level alliance across essential departments, dedicated to shared goal of addressing immediate needs and social determinants	1 Holistic 2 Responsibility 10 Build Infrastructure 12 Address determinants	Important to the knowledge of the evaluators and the project teams, there is no such alliance at high levels of government determining policy and practice models. Absent in two settings before project, AMSWS established a local alliance but could not enter the prison to activate pre-release care.
CLF2. Coordinated mechanisms for demonstrating shared accountability are operating at all levels	2 Responsibility 10 Build Infrastructure 12 Address determinants	Not available in any of the sites, only operated informally among some services.
CLF3. Agreements that essential information, e.g. dates of discharge and court hearings, is systematically shared among stakeholders within confidentiality limits	2 Responsibility 5 Strong relationships	Not available at any of the sites, so informal mechanisms were used to become aware of women being released
CLF4. Roles, responsibilities and expectations across sectors are clearly articulated and agreed upon with performance monitoring	2 Responsibility 5 Strong relationships 6 Community Capacity 12 Address determinants	Not in place at any of the sites. AMSWS advocated for and TMML achieved the preparation and signing of many MOUs with services to enhance coordinated support. This took many hundreds of phone calls, meetings and email messages to encourage and persist with the execution of the MOUs.
CLF5. Activities are guided and/or managed by experienced, skilled and empowered Aboriginal people* with clear understanding of needs, ways of working and solutions	1 Holistic 2 Responsibility 3 Cultural Leadership 8 Progressive	This was achieved at TMML and AMSWS, but GMML sought this out through its relationship with GRAMS, achieving it in the final months. GMML employed an accepted non-Indigenous person.
CLF6. Networks with the Aboriginal and Torres Strait Islander community and with service providers are seen as key assets for selection criteria in recruitment	1 Holistic 2 Cultural leadership 3 Strengths based 6 Community Capacity	As above, this was achieved at TMML and AMSWS, but GMML sought this out through its relationship with GRAMS, achieving it in the final months. GMML employed an accepted and experienced non-Indigenous person.
CLF7. Programs are well supported to implement mechanisms to collect culturally-informed data on program quality, needs assessment, process, impacts and outcomes and costs to enable demonstration of their value.	2 Responsibility 3 Cultural leadership 9 Spirit 11 Evidence base	As this was a formative evaluation, it was not expected that the sites would have progressed enough to conduct a meaningful summative (impact and outcome) evaluation or cost-benefit analysis. These are strongly recommended for the TMML site.

*or accepted, well connected and experienced non-Indigenous person with high cultural competency if a suitable Aboriginal person is not available

Table 4. Critical Resourcing Factors (CRFs) (modified Critical Growth Factors), associated cultural needs and values and application to the three case studies.

Critical Resourcing Factors* (Resources)	Nгаа—bi-nya Items identified in review	Importance, effort, challenges, mechanisms used to operationalize the Critical Factor in care pathways for women in Returning Home Back to Community
CRF1. Funding scheme is mindful of and responsive to the diversity of settings and peoples within the Landscape	1 Holistic 6 Community Capacity	Important, proposal sought enhance learnings by selecting pilot settings that encompassed substantial diversity of situations for women returning home.
CRF2. Pre-program consultations have included Aboriginal and Torres Strait Islander people with grassroots knowledge about the challenges being addressed	1 Holistic 2 Responsibility 3 Cultural leadership 4 Strong relationships	Very important, due to short timeframe for proposal submission and needs assessment, very little time available to consult with community, AMSWS is community organisation with elected board, TMML Aboriginal manager linked with Bindal Elder, GMML had difficulty due to lack of existing networks
CRF3. Project funding operates with flexibility and responsiveness to this local knowledge	2 Responsibility 5 Strong relationships	Very important, project funding was flexible and responsive, allowing sites to 'write their own story', difficult to gain the local knowledge due to short time
CRF4. Culturally-informed evaluation processes utilising appropriate tools and data collected in routine practice are conducted at appropriate times.	1 Holistic 2 Responsibility 3 Cultural leadership 11 Evidence base	Very important, given the short time frame of preparation to implementation to ending of the project, a substantial amount of evaluation was conducted by the evaluation team with Aboriginal researchers using processes and tools developed and shown to be highly effective in other Aboriginal settings
CRF5. Timeframes and expectations of process, impact and outcome are well aligned with realities on the ground and starting point	2 Responsibility 4 Strengths based 6 Community Capacity	Very important, not met in two sites where approvals were not granted to enter correctional centres preventing pre-release care coordination, also in one site where formal and informal networks were rudimentary, one site doing well but not yet reached its full potential
CRF6. Funding is continuous and enables steady growth of proven quality programs to meet overwhelming need	2 Responsibility 8 Progressive 12 Address determinants	Very important but not met to date, programs no longer funded or functioning, leaving women unsupported to face overwhelming challenges
CRF7. Funding supports programs to help build a skilled Aboriginal and Torres Strait Islander workforce able to work effectively and grow to meet need	2 Responsibility 3 Cultural leadership 10 Develop workforce 12 Address determinants	Very important, staff received training and/or experience, but only briefly attained in the pilot
CRF8. Accountability is flexible, minimally burdensome and internally managed allowing for quality improvement	2 Responsibility 8 Progressive 11 Evidence base	Important, this appeared to be met as no parties indicated accountability burden was heavy, reflection process of Muru Marri assisted GMML

Table 5. Critical Sustainability Factors (CSFs), reflecting Learning and associated cultural needs and values and application to the three case studies.

Critical Sustainability Factors* (Learning)	Nгаа—bi-nya Items identified in review	Importance, effort, challenges, mechanisms used to operationalize the Critical Factor in care pathways for women in Returning Home Back to Community
CSF1. Having an inclusive and inspiring origin and establishment processes beginning in the community	1 Wholistic 6 Community capac 8 Progressive	Very important, but harder to achieve given the rapid turnaround for proposals, but was facilitated by becoming attached to ongoing work of all organisations and, for TMML, linking up quickly with Community Elder.
CSF2. Embedding Aboriginal ways of being and doing from leadership to management to staff to foster authenticity at the interface with the women.	1 Wholistic 3 Cultural leadership 5 Strong relationships	Very important, operationalized at AMSWS and TMML, multi-layered mentoring at TMML from Bindal Elder to managers to staff, normal way of working for AMSWS
CSF3. Having the time and space to find the right path with the community, able to experience trial and error and emerge with a stronger local knowledge base	6 Community capac 8 Progressive 11 Evidence base	Very important but seriously restricted by the very short duration of the pilot, time was insufficient for GMML who did not already have a strong community or service network, for AMSWS the difficulty was with Corrections – not with the community
CSF4. Sharing vision of program potential to guide and motivate participants and staff through hard times	4 Strengths based 9 Spirit	Very important, the teams made constant references to the meaning and purpose of their work, kept them focused and courage to be persistent to move forward
CSF5. Fostering innovation in tools & processes for recruitment & training, program delivery, service collaborations, widen support, show accountability	8 Progressive 10 Workforce develop 11 Evidence base	Very important, all sites developed various useful tools and processes for the care coordination roles they played, including promotional materials and pamphlets to referral forms, assessment tools, pre- and post-release care plans, etc.
CSF6. Embedding meaningful accountability, monitoring, evaluation processes for continuous improvement	8 Progressive 11 Evidence base	Very important, but just developing for GMML, TMML-RHCCC used Medicare Local databases to record episodes of care for 126 women and could report on activities
CSF7. Having a mechanism to celebrate achievement, to emphasise the meaning and purpose of the work, to continuously reflect on ‘what are we doing, why are we doing it, how can we do better?’	5 Strong relationships 8 Progressive 9 Spirit 11 Evidence base	Very important, GMML was introduced to the Reflection Tool by the Evaluation team and used it regularly to foster reflective processes, operations of TMML were inherently reflective due to Aboriginal management/mentoring/yarning style (“the way do things”), similarly AMSWS employs a reflective approach in communications
CSF8. Creating a working environment and structure where staff are safe to be open and honest, discuss challenges, offer positive solutions to each other for support to deal with emotionally challenging work, the flexibility and resourcefulness required to preserve confidence	5 Strong relationships 8 Progressive 10 Workforce develop	Very important, all three sites recognised the importance of keeping the staff well in the face of difficult, sometimes heartbreaking work, all had ways to operationalise this support and saw it as an ongoing challenge. Where barriers in accessing and working with the women were overcome through resourcefulness, the positive outcomes supported staff wellbeing, where they weren’t, safe spaces were crucial.
CSF9. Managing change respectfully but firmly for the good of the program where necessary	2 Responsibility 8 Progressive	Due to the short term and focused nature of the project, there did appear to be occurrences where this was required and could be demonstrated.
CSF10. Focussing on developing and sustaining good relationships with stakeholders via communication, reliability and collaboratively meeting women’s needs.	2 Responsibility 5 Strong relationships 9 Spirit	Extremely important, all sites recognised and sought to maximize these relationships as essential. Tools and processes developed at all sites, persistence and flexibility in ways of working crucial. Difficulty with negative stakeholders was biggest challenge.



Table 6. Critical Effectiveness Factors (CEFs), reflecting Ways of Working and associated cultural needs and values and application to the three case studies.

Critical Effectiveness Factor* (Ways of Working)	Nгаа—bi-nya Items identified in review	Importance, effort, challenges, mechanisms used to operationalize the Critical Factor in care pathways for women in the Returning Home Back to Community from Custodial Care
CEF1. Adopting full commitment to working from strengths, not seeking to correct deficits	1 Holistic 4 Strengths based 9 Spirit	Confirmed to be very important from all case studies and the literature. Well practiced in the approaches adopted by all three sites. Different from punitive and biomedical approaches
CEF2. Being patient to develop the relationship bond first, then using the relationship to move towards positive change	3 Cultural leadership 5 Strong Relationships 8 Progressive	Confirmed to be very important. Shown to be absolutely essential and of central importance to TMML with substantial gains. Caused difficulty for AMSWS and GMML when access to the women in the Centres not approved, was impossible to strong relationships pre-release.
CEF3. Modeling reliability and being consistent; staff doing what they say they will do to build and maintain trust and to show they care	2 Responsibility 5 Strong relationships 10 Workforce develop	Confirmed to be very important and demonstrated at all three sites. Withdrawal of approval for entry for AMSWS team interfered with ability to follow through, causing distress.
CEF4. Facilitating connection to culture, showing how to be a strong Aboriginal person through individual, group, community engagement	1 Wholistic 2 Responsibility 3 Cultural Leadership 6 Community capacity 9 Spirit	Multiple activities of TMML in planning and referrals, supporting delivery of the Bindal Leadership Program through the Community Elder/Leader facilitated peer support for healing, close connections with community and cultural role modeling. AMSWS offers this for all women accessing the service and programs like Golden Oldies, GMML's link with GRAMS made this increasingly possible. Aboriginal leadership, Aboriginal staff.
CEF5. Adopting a non-judgmental approach, using mistakes as a way to build new skills for better choices	4 Strengths based 8 Progressive 9 Spirit	Emphasis on creating a safe space where the women would not feel judged was very strong and trusting relationships enabled learning from mistakes, strongly emphasized in TMML case management activities, empathetic approaches confirmed with demand for teams
CEF6. Setting rules and boundaries around what's okay, what isn't in a way directly applicable to everyday life; e.g. respect, two-way reliability	2 Responsibility 5 Strong Relationships 8 Progressive	Bindal Leadership Program has explicit focus on learning life skills, all teams aware of the need to be patient and empathetic in understanding the burden carried by many of the women and the need to role model responsible relationships at all times
CEF7. Modeling openness, honesty, hope, trust	3 Cultural Leadership 9 Spirit	Recognised by all as essential for working safely and effectively with women wherever they are in their incarceration status, these qualities assisted in meeting them at a deeper level
CEF8. Maximizing opportunity for choice making, self-motivation, feeling safe to try new things	3 Cultural leadership 8 Progressive 9 Spirit	Confirmed important by all, particularly embodied in the Yarning Circles organised by TMML where women took the lead in selecting and dialoguing with service providers, also in the care planning processes underpinning all individual care provided
CEF9. Celebrating small achievements and positive changes and using these as a leverage towards autonomy	4 Strengths Based 8 Progressive 9 Spirit	Confirmed important by all, particularly demonstrated in the Graduations from the Bindal Leadership programs where women were congratulated by senior Correctional Centre officials and senior Medicare Local managers, part of all individual care



Appendix A1. Case study report for Geraldton site



Returning Home, Back to Community from Custodial Care

First Year Pilot Project

Evaluation Report for Geraldton Site

August 2014

This case study was conducted as a partnership between the project evaluators:
Muru Marri, School of Public Health and Community Medicine
University of New South Wales
Sydney, NSW

and the project developers and deliverers:
Goldfields-Midwest Medicare Local in collaboration with
Geraldton Regional Aboriginal Medical Service

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Canberra, Australian Capital Territory

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Acknowledgements

In the spirit of respect, we acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia.

This work was done on the land of the Yamatji peoples who are and always will remain the traditional owners of the land that is known today as the Midwest region of Western Australia and are recognised for their continuing connection to land, waters and community.

This case study, which is part of a national pilot project funded by the Department of Health, aimed to produce a mutually useful product that reflects the knowledge and experience of the program developers, deliverers and evaluators. The partners—Muru Marri and Goldfields-Midwest Medicare Local in collaboration with Geraldton Regional Aboriginal Medical Service—share a common goal; that the story that has emerged can be of local benefit and also inform and inspire other programs for Aboriginal and Torres Strait Islander women going back to community after a custodial sentence.

Special thanks go to Jacki Ward for organising the interviews for the two site visits and to all the stakeholders who gave their time to ensure the evaluators gained a clear understanding of the strengths and challenges faced in their efforts to support Aboriginal women prisoners returning home.

Finally, we acknowledge the support and contributions of our colleagues at Muru Marri.

Acronyms

DCS	Department of Corrective Services
DOH	Department of Health
GMML	Goldfields-Midwest Medicare Local
GRAMS	Geraldton Regional Aboriginal Medical Services
GRC	Geraldton Resource Center
SPRINT	Services and Primary health care needs for Recently Released Inmates in Need of Treatment and health management
WACHS	Western Australia Country Health Service



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Prologue: Introduction to Returning Home

Returning Home, Back to the Community from Custodial Care (henceforth Returning Home) is a national project funded by the Commonwealth Department of Health. The project aims to develop effective models of care that will enhance the health and wellbeing of Aboriginal and Torres Strait Islander women who are returning to the community from prison. The first year pilot project has been implemented at three sites around the country: Geraldton in Western Australia, Townsville in Queensland and Blacktown in New South Wales.

Muru Marri, an academic unit of the School of Public Health and Community Medicine at UNSW Australia, was commissioned to undertake an evaluation of the pilot project, using a case study approach to tell the story of the progression of plans at each location—from the initial ideas to the final model of care. This report documents the people and processes involved, the challenges encountered, the model developed and the lessons learned in Western Australia.

Returning Home, itself, emerged from the Services and Primary health care needs for Recently released Inmates in Need of Treatment and health management (SPRINT) project, which sought to provide a culturally-specific understanding of how primary health care services can improve health care and social support for Aboriginal people in contact with the criminal justice system and transitioning back into the community. The necessity for a wholistic and integrated case management approach was highlighted. Returning Home gave the opportunity for Medicare Locals and Aboriginal Medical Services, working with other health and community service providers in diverse regions of Australia, to create and implement a culturally and locally-appropriate model that incorporated such an approach.



Executive summary

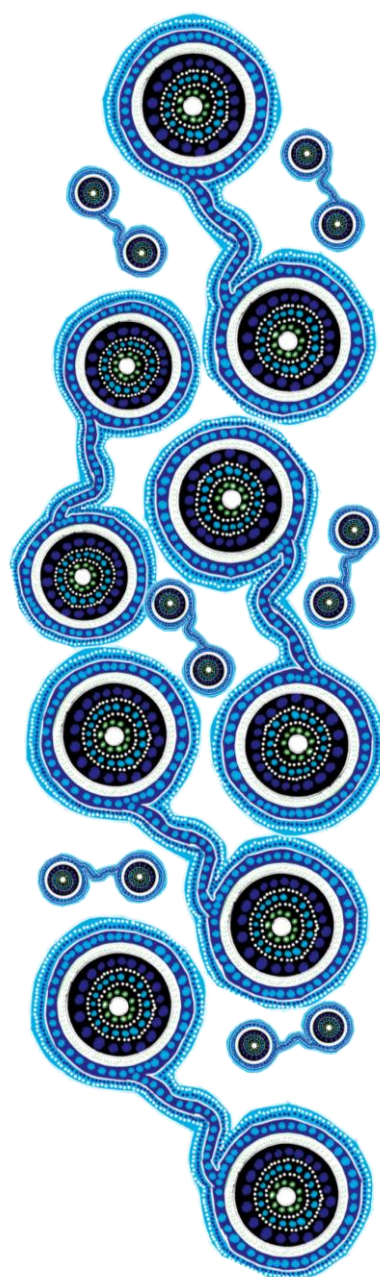
Aboriginal and Torres Strait Islander women returning home after serving a custodial sentence face enormous challenges including multiple long-standing health and wellbeing issues, which, like their incarceration, stem from the devastating loss of land, culture and family caused by colonisation and the social, economic and educational disadvantage that continues today. To properly address these issues requires access to coordinated and culturally-appropriate programs targeted to Aboriginal and Torres Strait Islander women that are based on a wholistic throughcare model and incorporate reception planning, case management, transitional programs and mental health support.

The Returning Home pilot project, funded by the Commonwealth Department of Health, was designed to build an improved understanding of the most appropriate model of care that Aboriginal and Torres Strait Islander women can expect from community-based service providers who are focused on improving their health outcomes, especially those related to mental health. Geraldton, with the nearby Greenough Regional Prison, was chosen as one of three pilot sites nationally. As the model of service delivery was still evolving, this case study incorporated a participatory action research approach. Data collection methods comprised in-depth interviews and document analysis.

Returning Home personnel at the Geraldton site comprise a part-time Coordinator employed by Goldfields–Midwest Medicare Local (GMML) in August 2013 and full-time Social Worker employed by Geraldton Regional Aboriginal Medical Service (GRAMS) in February 2014. Returning Home presented GRAMS with an opportunity to complement their existing Re-Entry program, staffed by two Aboriginal Health Workers, by providing greater support to female prisoners on their release and by extending the support to start as early as possible, including pre-sentencing.

Key elements of the emerging model include a culturally-appropriate, wholistic and strengths-based approach, inter-agency and multi-sectoral collaboration, and community-based health and social interventions with a focus on family and peer support. The Returning Home Social Worker performs a wide range of duties including direct client care (assessment, counselling, coaching, referral to health and other services and case management); outreach and community visits, often with other service providers; stakeholder engagement; and individual and community advocacy. In the four months from March to June 2014, she worked with eight post-release clients and two pre-sentencing clients. Three women were interviewed in preparation for their release and four were referred to other post-release services.

Early feedback has been positive. While more time is needed for the project to be fully implemented and evaluated, the Geraldton experience provides several lessons for initiatives to support Aboriginal women going back to the community from custodial care. Gender-sensitive and culturally-appropriate services that operate from a community base and incorporate known critical effectiveness factors for improving social and emotional wellbeing are more likely to be effective in the long-term. At the same time, the underlying issues and upstream social determinants of health must be addressed. The evaluators recommend that GRAMS seeks funding to continue development and implementation of Returning Home in Geraldton and that an interim evaluation, based on the framework and measures proposed in this report, is conducted in July 2015.



Artwork representing “the importance of establishing and maintaining links with community, organisations and family” designed for GMLL use by Maxine Ryder.

Background

Aboriginal and Torres Strait Islander women returning home after serving a custodial sentence face enormous challenges. Many are burdened by multiple long-standing health and wellbeing issues, which, like their incarceration, stem from the devastating loss of land, culture and family caused by colonisation and the social, economic and educational disadvantage that continues today. Health problems include substance misuse, mental disorders, blood-borne viruses (Hepatitis A and B) and chronic diseases such as diabetes and cardiovascular disease. These make it even harder for the women to deal with all of the requirements of returning to their home, meeting their basic social, emotional and physical needs and re-establishing roles and relationships with their families and communities (SPRINT Project Team, 2013).

As identified in the SPRINT project, to properly address these issues requires access to coordinated and culturally-appropriate programs targeted to Aboriginal and Torres Strait Islander women that are based on a wholistic throughcare model and incorporate reception planning, case management, transitional programs and mental health support. Linking the women with safe and secure housing as well as with primary health care and community services is fundamental to ensuring positive outcomes. Provision of support structures that enable re-engagement with a comprehensive range of services and employment opportunities offers their best chance for not returning to custodial care (SPRINT Project Team, 2013).

The Returning Home pilot project was designed to build an improved understanding of the most appropriate model of care that Aboriginal and Torres Strait Islander women can expect from community-based service providers who are focused on improving their health outcomes, especially those related to mental health. In addition, the evaluation team was tasked with identifying the best approach in primary health care service delivery that enables improved transition arrangements for this client group; and the learnings that can lead to developing a model of care arrangement for the wider cohort of post-custodial care clients.

Geraldton site

The Goldfields–Midwest Medicare Local (GMML) was invited by the Commonwealth Department of Health to conduct the Western Australian arm of the pilot project. Compared with the other two sites (Townsville in northern



Queensland and Blacktown in the western suburbs of Sydney), this site covers a large geographical area and has a high proportion of Aboriginal residents.

Project aim

The service agreement between the Department and the GMML, described the project aim as follows:

“to provide support to Aboriginal and Torres Strait Islander women returning back into the community from their recent custodial sentence. This includes providing culturally appropriate support and guidance to enable engagement and connection with relevant service providers in the area of primary health care (including AMS providers), mental health services, family support officers, women health and wellbeing providers. Importantly there is a need to link health care service outcomes during custodial care to ongoing primary health care in the community. Finally the clients should be enrolled in Personally Controlled Electronic Health Record (PCEHR) program.”

Project setting

The GMML, which includes the Midwest, Gascoyne and Goldfields–Esperance regions of Western Australia, covers an area of 1,373,296 km², representing 54.4% of the state and 18% of the country. It is relatively sparsely populated, especially in the inland, with an estimated population in 2011 of only 127,448 people which is equivalent to 5.4% of the Western Australian population. Approximately 9.4% of residents identify as Aboriginal and/or Torres Strait Islander. Their overall health status is poor and providing any health care, including mental health care, especially to those living in small remote communities, is challenging (GMML Annual Plan, 2013-2014).

The Midwest region alone covers an area of more than 470,000 km², with Geraldton as its regional centre. The population is concentrated along the coast with more than 70% living around the City of Greater Geraldton.

Greenough Regional Prison is located 16 km to the south of the city. The prison accommodates approximately 330 prisoners of all security levels (maximum, medium, minimum and remand). A recent extension has allowed the prison to manage 70 female prisoners, up from 25. In September 2013, there were 69 women incarcerated, 95% of whom identified as Aboriginal. Most have drug-related convictions and are serving sentences of less than 12 months. They come from various places within the Midwest and Gascoyne regions as well as from Perth and other parts of the state. In fact, only a minority expect to be “returning home” to Geraldton and neighboring Midwest towns.

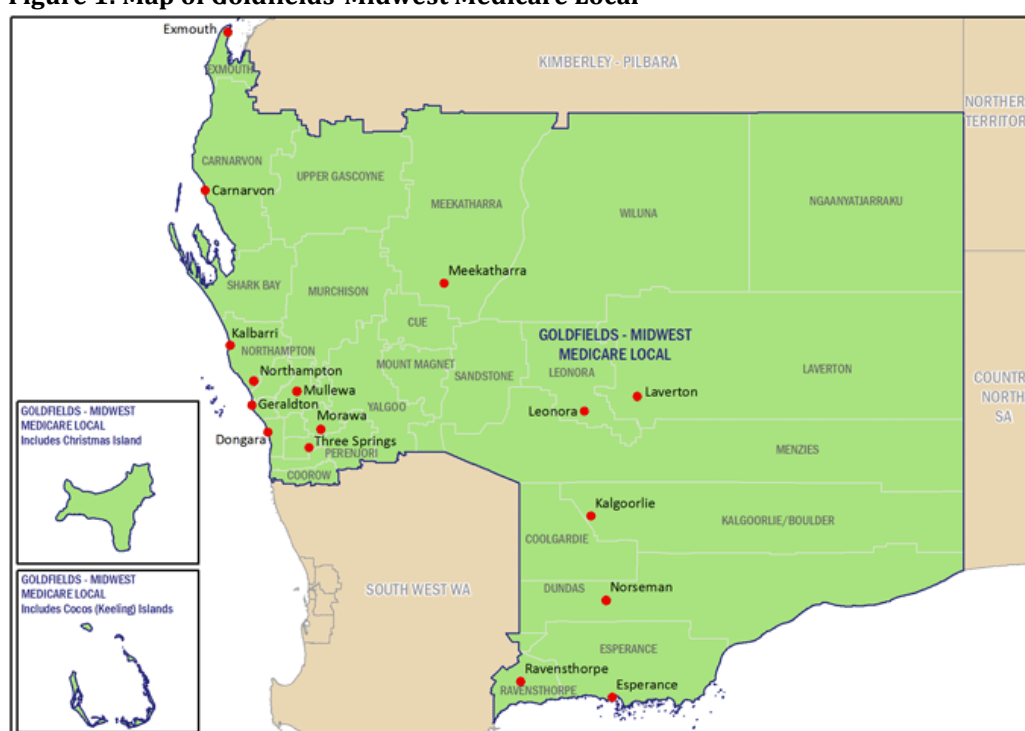
The prison has a 7-days-a-week health clinic operated by nurses. General Practitioner (GP) services were provided by Geraldton Regional Aboriginal



Medical Service (GRAMS) until mid-2013, but are now provided by a single doctor who visits 2–3 times per week. A public health doctor visits once a week. A dentist and a dietitian visit once a month.

A medical assessment is conducted with all prisoners on reception and clinic staff continue to monitor their health needs whilst they are incarcerated. Psychological services are provided during office hours. Appointments for specialist medical services available in Geraldton, such as cardiology, are made for the prisoner and transport arranged for them to attend. If the appointment time is after their release date, an appointment card is given to the prisoner on their release from prison.

Figure 1: Map of Goldfields-Midwest Medicare Local



Evaluation approach and methods

The Western Australian case study incorporated a participatory action research approach, with the Muru Marri team feeding back learnings and insights and contributing other information that could be useful (eg the SPRINT project summary) as the study progressed. Two project newsletters, produced in January and May 2014, provided a means of sharing information about developments across all project sites.

Regular teleconferences with the Returning Home Coordinator from February to July 2014 supported updates on progress and planning for field visits. Appendix



1 contains the reflection diary, a tool developed to prompt the coordinators to reflect on the work conducted, the learning processes and the main challenges.

The data collection methods comprised in-depth interviews and document analysis. The majority of interviews were conducted during two field visits in mid-March and late-June. In the few cases where people were unavailable at those times, telephone interviews were arranged. Appendix 2 contains a list of people and organisations consulted and Appendix 3 contains the guide for the semi-structured interviews. Our formal consultations included staff from GMML, GRAMS, Department of Corrective Services, Western Australian Country Health Service, and several non-government organisations. We were also invited to have coffee with two program participants who shared their experiences of the program.

The documents reviewed included the GMML Returning Home proposal and progress reports, including needs assessments; other GMML information and reports; the GRAMS Strategic Plan 2010-2015; the Batavia Primary Health Care Service Directory; *Breaking the Chains*, an information booklet for people getting out of prison in the Midwest developed by Geraldton Resource Centre; and information brochures for community services and programs in the area.

Figure 2: Photo taken during first field visit, from left to right: Ilse Blignault (Muru Marri), Sonya Crane (GRAMS), Jacki Ward (GMML) and Marcia Grand Ortega (Muru Marri)



Project implementation

Key activities and decisions taken in development of the project are outlined in the Table 1, below.

Table 1: Project Activities

Month	Activities
June 2013	<ul style="list-style-type: none"> • GMML invited by DOH to conduct Geraldton pilot project • Decision to focus on Midwest region and Greenough Regional Prison
Aug 2013	<ul style="list-style-type: none"> • GMML RH Coordinator employed
Sep 2013	<ul style="list-style-type: none"> • Midwest needs assessment completed and report submitted to DOH • National meeting with all project sites on 13 September, Canberra
Oct 2013	<ul style="list-style-type: none"> • Goldfields needs assessment completed and report submitted to DOH • Decision to focus on Midwest region confirmed • Discussions between GMML and GRAMS for possible collaboration
Nov 2013	<ul style="list-style-type: none"> • First national teleconference with all sites, 1 November
Dec 2013	<ul style="list-style-type: none"> • GMML and GRAMS collaboration confirmed – RH Social Worker to be employed by GRAMS to work outside prison • Progress report submitted to DOH
Jan 2014	<ul style="list-style-type: none"> • Second national teleconference with all sites, 28 January
Feb 2014	<ul style="list-style-type: none"> • GRAMS RH Social Worker employed
March 2014	<ul style="list-style-type: none"> • First evaluation visit by Muru Marri • First visit to prison by GRAMS RH Social Worker
May 2014	<ul style="list-style-type: none"> • Stakeholder meeting including GMML, GRAMS, GRC, DCS, Straight Talk
June 2014	<ul style="list-style-type: none"> • Second evaluation visit by Muru Marri • Evolving project model documented with RH Coordinator and RH Social Worker
July 2014	<ul style="list-style-type: none"> • Evaluation report submitted to GMML

The Midwest needs assessment noted the recent increase in the women's population at Greenough Regional Prison and confirmed the decision to focus on the Midwest region. The needs assessment also found that prisoners being released into Geraldton and surrounding areas were supported by a range of services provided by different government departments and agencies and non-government organisations. However, these were not well coordinated.

The Department of Corrective Services (DCS) funds transition/reintegration services both inside and outside the prison. Within the prison, the Women's Support Officer, the Transitional Manager and the Prison Employment Officer work closely with women to advocate for their needs and facilitate their access to health, housing, employment and other services. The DCS also funds a Re-Entry Program, administered in Midwest by the Geraldton Resource Centre (GRC). Support is available to prisoners serving sentences longer than one year during the six months pre-release and up to 12 months post-release. A major focus is arranging suitable post-release accommodation. A monthly meeting,



chaired by the prison superintendent, provides a forum to discuss referrals and follow-up.

The Western Australian Country Health Service (WACHS), through the 'Close the Gap in Aboriginal Health' initiative, funds a state-wide Aboriginal Health Community Re-Entry Program. In Geraldton this administered by GRAMS who employ a male and female Aboriginal Health Worker to link Aboriginal people with appropriate community health services before and after release from custody. Like the DCS Re-Entry program, the focus is six months pre-release and up to 12 months post-release.

The Returning Home Pilot Project presented GRAMS with an opportunity to complement their Re-Entry program, with a greater level of support to the women on their release and by extending the support provided to start as early as possible (even before sentencing). A non-Aboriginal social worker who had worked with GRAMS previously and was known and respected in the local community was employed for this role.

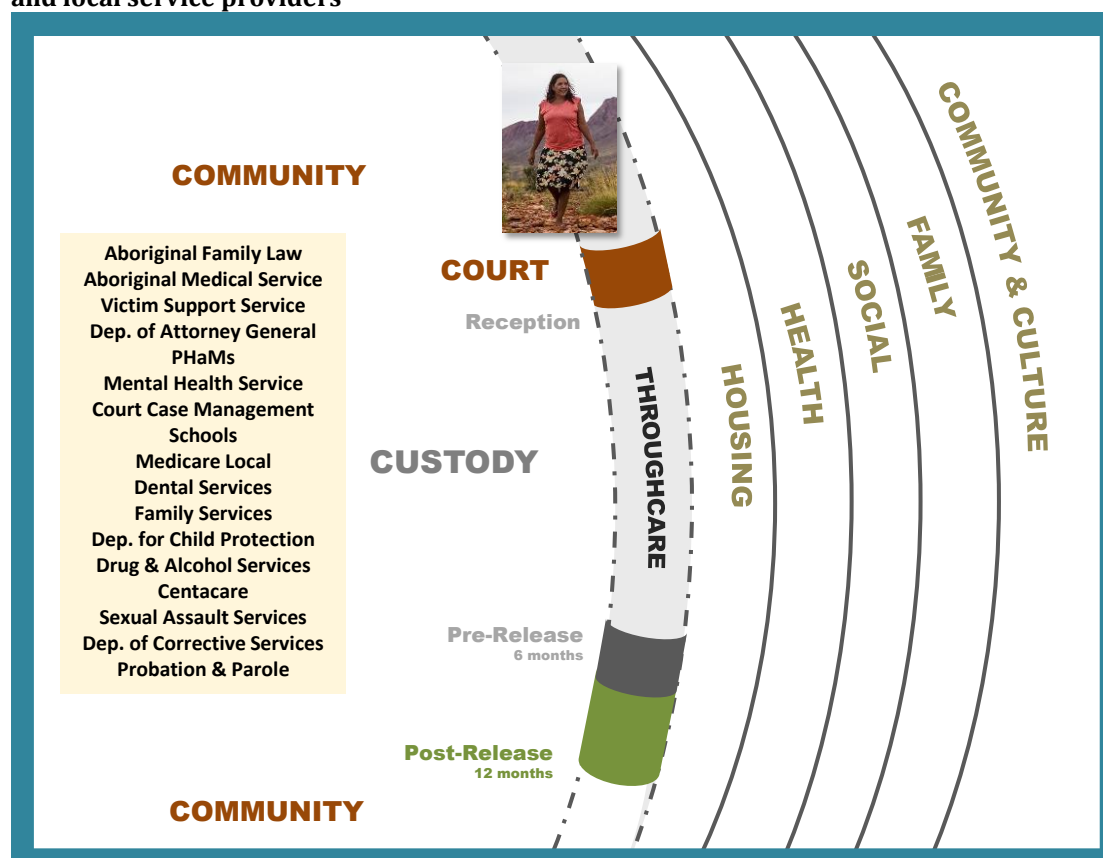
The enrolment of Returning Home clients into the Personally Controlled Electronic Health Record program is temporarily on hold pending a Commonwealth Government review. The Gold Health system is currently being actively promoted in the Midwest region.

Evolving model of service delivery

Service environment

It is early days and the model of service delivery is still evolving. Figure 3 shows a woman's journey from the community through the criminal justice system and back to the community ('throughcare' is current policy), her needs (housing, health, social, family, community and culture), and some of the services and organisations involved (Aboriginal Family Law, Aboriginal Medical Service, DCS and so on).

Figure 3: An Aboriginal woman's journey, her service and support needs and local service providers



A range of service providers are involved in the court processing and sentencing phase. Barndimalgu Court, which hears family and domestic violence matters involving Aboriginal men, plays an important role in many cases.

Within the prison, in addition to the two Re-Entry programs, an Integrated Offender Management Support Strategy is being piloted (new since the needs assessment), with an emphasis on individualised and integrated case management. The Women's Support Officer assesses all female prisoners' needs on reception to later refer them to the different agencies required. She builds rapport and earns the women's trust, becoming the main internal point of reference for their needs, including child and family issues, legal issues, education, employment, housing and so on. Within the prison, the women can choose to attend various programs to enhance their life skills, improve their employability and help them connect to their culture. DCS psychologists provide counseling and conduct therapeutic groups. Because the prisoners come from all over the state, acknowledgement of diverse cultures and traditions is important.

To date, Returning Home has focused on providing post-release support to Aboriginal women on the completion of their custodial sentence. There has been a small pre-sentence component to the work, as described in the following section.



The service providers interviewed identified access to secure long-term accommodation and custody of, or access to, their children as the main issues for Aboriginal women returning home. The limited availability and excessive waiting period for social housing and the high cost of private rentals is a major problem in Geraldton. The situation is even worse for women returning to remote areas. Returning to their former home or to live with family is problematic when it means returning to a place of heavy drug use and violence. Several service providers raised the issue of safety, eg:

“She got scared for her life and put herself in prison ... We see how scared they are to come out ... That is why recidivism will never stop, because they are scared, it’s harder out there than in prison.”

Aboriginal women in prison have a full range of health—including women’s health—needs. Aboriginal mothers have additional concerns: who will care for their children during their incarceration; who is liaising with the many organisations and individuals that need to be involved (eg Department for Child Protection, courts, schools and family); how can they regain custody on their release?

Aboriginal women returning home to remote areas—and those wanting to support them—face additional challenges such as scarce employment and education and training opportunities, limited transport and access to services generally, and isolation. Limited health services are compounded by a health workforce shortage across the Midwest region.

Elements of the model

Many informants highlighted the strengths of the Aboriginal women as well as their multiple needs for support. Returning Home has adopted a culturally-appropriate, wholistic and strengths-based approach. Other key elements of the evolving model include inter-agency and multi-sectoral collaboration, and community-based health and social interventions with a focus on family and peer support.

Strengths-based approach

The interactions with women will focus on their strengths rather than their deficiencies. Returning Home will foster empowerment rather than dependency, facilitate family and community involvement, build social competencies, connect with education and training opportunities, and emphasise the significance of Aboriginal culture (adapted from Goulding 2006).



Inter-agency and multi-sectoral collaboration

Close collaboration between the GRAMS Returning Home Social Worker and 'Case Managers' in other agencies will support effective communication and comprehensive and continuous support for the women at different stages of their journey. Effective relationships, based on a common goal and mutual respect, between organisations and service providers will help the women to navigate through the service system, obtain the assistance they need and realise their potential. As one service provider remarked: *"It's a matter of committing to one another, working together!"*

Community-based interventions, with focus on family and peer support

Emphasis on upstream social determinants of health and wellbeing is critical to helping reintegrate Aboriginal women into the community and making a long-term impact on recidivism rates. Community-based interventions involve working with the extended family, community members and others (including child care and protection services), building capacity (including cultural competence), and linking service providers with the community and each other.

Immediately after release, women are particularly vulnerable. The purpose of the Returning Home program is *"to wrap women up in post release support so as to; reduce rates of recidivism, improve health outcomes, re-build relationships within the community and tackle issues that were left untreated whilst incarcerated these including; sexual abuse, addiction, domestic violence and homelessness"* (GRAMS Returning Home Program Plan, 2014).

The Returning Home Social Worker has also identified court processing as an early opportunity for intervention with this client group. Connecting clients with relevant health and community service providers and supportive family will help ensure that all necessary support is in place during and after incarceration. In addition to reducing the stress of incarceration by determining post-release living and other arrangements in advance, this may also help to minimise the woman's sentence.

Roles and activities

Funding for the pilot project was allocated to GMML who recruited a Returning Home Coordinator (part-time) who conducted the Midwest and Goldfields needs assessments and has provided an important coordination role with stakeholders throughout the project development and implementation phases. Fairly early, GRAMS was identified as the most suitable home for a program such as this due to their experience in providing culturally-appropriate primary health care services to the Aboriginal community and long-standing commitment to prisoner health. Through the WACHS-funded Re-Entry Program, GRAMS already employed two Aboriginal Health Workers to work with this high-needs group.



Using the DOH funding for this pilot project, GRAMS employed the Returning Home Social Worker.

In the development and early implementation phase, the Returning Home Coordinator role has been critical. It is unlikely that the program would have achieved what it has, given the amount of development work required [assessing client needs and service gaps, bringing stakeholders together, facilitating communication etc] without her skills and experience (community nurse, researcher, project officer) and dedication. The skill set, resourcefulness and passion of the Returning Home Social Worker, and her strong relationships with the Aboriginal community, have been equally critical to achievements to date.

The Returning Home Social Worker performs a wide range of duties including direct client care (assessment, counselling, coaching, referral to health and other services and case management); outreach and community visits, often with other service providers; stakeholder engagement; and individual and community advocacy. Her culturally-sensitive and caring approach is demonstrated in the time she takes in building rapport with the women and exploring their immediate and longer-term goals. Assessment is often conducted as a conversation over a cup of coffee, and may take several sessions.

“Women [released from prison] want someone to talk to; they are more often than not scared of being released back into the community. Women are unprepared, nervous and scared about their future.”

(GRAMS Returning Home Program Plan, 2014)

Access to and communication with services is a problem for most of the women. This is addressed by arranging transport to appointments, providing assistance with phone plans, phone cards and phones when necessary; as well as making phone calls on behalf of clients.

To increase the women’s access to essential hygiene and other products on release from prison, each one is given a present of a special health bag.

“This bag was developed with the primary aim of acknowledging that very often women being released from prison are homeless, have few personal belongings and are suffering with identity issues as a result of institutional living and no sense of self. The bag is tailored to suit individual women’s needs, likes and colours. The contents include a comprehensive toilet bag with a focus on personal hygiene, oral health and sexual health. Other contents include towels, pyjamas, journal and a small gift that sees the client. [The bag is also a] token of appreciation for their trust and sharing of stories, which are an important part of healing, however they are traumatic and confronting.”

(GRAMS Returning Home Program Plan, 2014)



Case studies

In the four months from March to June 2014, the Returning Home Social Worker worked with eight post-release clients and two pre-sentencing clients. Three women were interviewed in preparation for their release. Four women were referred to other post-release services.

The following case studies, written in general terms, are illustrative of the work that has been done. Names have been changed and details that may identify the person have been altered. The first case describes a pre-sentencing intervention. The second and third cases describe post-release interventions with two women who went to live with family in Geraldton. Their interventions focused on health, family and children, education and general life skills. For other women without a place to live, as in the fourth case, accommodation is a priority.

Case 1: Pre-sentencing

Sally, who is awaiting court sentencing for a drug-related conviction, was referred to the Returning Home Social Worker in her former job and she has continued to be involved in the case (referral from GRAMS). Sally does not use drugs herself but her husband has a drug addiction. From the outset, the Social Worker worked not only with Sally but also with her husband, mother, grandmother and the children. Links were made with the Department of Child Protection, the school principal, psychologists (arranged through GMMML) and Aboriginal Family Law. All agencies and services continue to be engaged and it is possible that, given this level of support, the length of her sentence could be substantially reduced. During incarceration, the Social Worker will help sustain the family connections, taking her children and mother to visit Sally in the prison.

Case 2: Post-release

Terri and the Returning Home Social Worker first established contact when Terri was in prison. At a chance meeting at the Geraldton shops a couple of weeks after her release, Terri asked for help and the Social Worker arranged a meeting.

Terri has a long history of drug use and physical and mental health problems. Her husband is currently in prison and she is living with his parents. Her children live with her former husband and his new partner. After a lengthy period of incarceration, she found the lack of structure on the outside overwhelming, with anxiety and panic attacks. The Social Worker provided emotional support and helped her make medical and dental appointments, including arranging to have her teeth fixed. The GRAMS GP arranged referral to a psychologist. The Social Worker also helped Terri enroll at TAFE to finish the cooking course she had started in prison.



Case 3: Post-release

Susie, also a former drug user, was referred to the Returning Home Social Worker through Terri with whom she had become friends in prison. Released at around the same time as Terri, she moved straight back into her former house where her husband and children were waiting. The Returning Home Social Worker assisted her with enrolling in a journalism degree.

Terri and Susie are now helping the Returning Home Social Worker to engage other women being released from prison and are keen to develop a peer-support network. They have started collecting a wardrobe of good second-hand clothes to offer women on their release as many put on weight and their old clothes no longer fit.

Case 4: Post-release

Linda was referred to Returning Home Social Worker by DCS for assistance with meeting her post-release healthcare needs. As a long-term recidivist with long history of addiction and mental health problems and no family support, Linda required intensive support. On release she was provided with a food hamper as well as a Returning Home pack with essentials to address personal hygiene. The Social Worker arranged accommodation in the town centre to minimise the stress associated with lack of transport, connected her with the community methadone program and dispensing pharmacy, took her to GRAMS and made appointments with a GP and psychologist, and took her to meet with Community Drug Service Team. During the initial few weeks she also phoned regularly and made home visits.

Proposed framework for summative evaluation

Evaluation is the analysis of information collected during routine monitoring or at other appropriate times for the specific purpose of *“identifying the efficiency, effectiveness and appropriateness of programs against some predetermined yardstick”* (NAHSWP 1989, p. 219). A formative evaluation such as this is a method for judging the worth of a program while the program activities are forming. A summative evaluation, on the other hand, is a method of judging the worth of a program after the program activities are fully implemented (Owen & Rogers, 1999).

The focus in a summative evaluation is on outcomes. If Returning Home is successful, the Aboriginal women involved will have improved health and wellbeing and reduced recidivism.



At the service level, in addition to the total number of women engaged, summative evaluation measures should reflect the types of assistance provided. Examples include:

- housing—how many clients have suitable accommodation
- health—how many clients have a regular GP, how many are in counselling or have a mental health care plan
- social—how many clients are employed or enrolled in a course, how many have been in trouble with the law or re-incarcerated
- family—how many clients have regular access to their children
- community and culture—how many clients participate in community and cultural events.

At the individual level, the summative evaluation should assess the extent to which the clients consider they have reached their own goals. Client stories and case studies collected on a periodic basis will provide important qualitative information. Consistent with the wholistic model of care, all case studies should consider the whole person and the combined input of the Returning Home Social Worker and others; not just one aspect of the client experience.

Lessons learned

The Geraldton pilot project, while more time is needed for it to be fully implemented and evaluated, provides several lessons for initiatives to support Aboriginal women going back to the community from custodial care.

The unexpected opportunity presented to GMML by the pilot project meant that the project commenced before partnerships were in place. Once a project officer (Returning Home Coordinator) was appointed and the needs assessment and service mapping completed, it was apparent that GRAMS would provide a more appropriate base for service delivery. Funds were transferred to GRAMS who employed the Returning Home Social Worker.

The landscape was well-described in the Midwest needs assessment conducted in September 2013. At that time there were 69 women incarcerated at Greenough Regional Prison, almost all of whom identified as Aboriginal. The needs assessment found that women being released into Geraldton and surrounding areas were supported by a range of services provided by different government departments and agencies and non-government organisations. Eligibility criteria varied and, overall, the services were not well connected and coordinated. At meetings arranged by the Returning Home Coordinator several of the prison and community-based providers discussed ways of working together for the first time. This was an important achievement as the cultures of



corrections (custody) and health and community services (care and support) are very different.

It became clear that women from the Midwest region constituted a minority of the female prisoners. To implement Returning Home for women coming from other places with Greenough Regional Prison as the starting point would require linking up with services in Perth and other regions of Western Australia.

The shortage of skilled health professionals to develop and deliver services is a common problem in regional Australia. The GMML and GRAMS Chief Executive Officers both considered recruitment of the right people was critical to the project's success. Once appointed, the Returning Home Coordinator and Social Worker both had a major impact on its direction and shape.

At a strategic level, the establishment of partnerships was highlighted as an important foundation to inter-agency cooperation and collaboration. Building partnerships takes time and resources. Improved communication between service providers from different sectors (health, community services and corrective services) brought improved understanding of the nature and extent of the range the services available, including eligibility criteria and referral pathways, as well as new opportunities for care coordination. Ensuring Aboriginal input and employing skilled Aboriginal staff is key to ensuring that services are culturally-appropriate.

Service providers highlighted the need for working on upstream social determinants of health, in order to effectively helping reintegrate women into the community and make an impact on recidivism. The health and wellbeing of Aboriginal women must be seen—and addressed—using an Aboriginal lens:

"To Aboriginal people, health is "not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life" (NAHSWP 1989, p. x).

Finally, in a setting chosen by the Department of Health and where no preparatory work had been done, 12 months was too short a time for a pilot project such as this. Significant time was required for the establishment phase including stakeholder engagement, staff recruitment and service development. The GMML/GRAMS Returning Home model of service delivery is still evolving.

Conclusion

Programs for Aboriginal women must be both gender-sensitive and culturally appropriate. A recent review of good practice in women's corrections (Bartels &



Gaffney, forthcoming) found that corrections systems tend to be organised around the needs of male prisoners, with special provisions for women being 'added on'. The SPRINT project highlighted the necessity for a wholistic and integrated approach to address the health and wellbeing challenges faced by Aboriginal people going back to community from custodial care. Aboriginal women's ability to access housing, family support and health (including mental health) and other services are key their successful reintegration (SPRINT Project Team 2013; Williams, 2014).

Culturally-appropriate services that operate from a community base and incorporate known critical effectiveness factors for improving social and emotional wellbeing are more likely to be effective in the long-term. In the early stages, in addition to taking a strengths-based approach, these include: being patient to develop a relationship bond first, then using the relationship to move towards change; modelling reliability and consistency; facilitating connection to family, community and culture; adopting a non-judgmental approach, using mistakes as a way to build new skills for better choices; setting rules and boundaries; maximising opportunities for decision-making and self-determination; and celebrating small achievements and positive changes (Haswell et al., 2013). At the same time, the underlying issues and upstream social determinants of health must be addressed (RCADC, 1991; Davis & Brands, 2007).

Recommendation

Based on the literature and the findings from this formative evaluation, the evaluators recommend that GRAMS seeks funding to continue development and implementation of Returning Home in Geraldton and that an interim evaluation, based on the proposed framework and measures, is conducted in July 2015.



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Appendices

Appendix 1: Reflection diary

You can use the template below to help you reflect and keep a record of your ideas for our next discussion

Learning log				
Date	What challenge are you trying to address?	What progress have you made?	What did you learn about what worked well?	What did you learn about what didn't work?
<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: 0 auto;"> What does this mean that we need to keep doing or do differently? </div>				

Returning Home Reflection Diary

Appendix 2: List of people and organisations formally consulted

- Alison Adam, CEO, Chrysalis
- Annette Pepper, WA Country Health Service, Community Drug Service Team
- Brenda Ryan, CEO, GMML
- Caroline Williams, Senior Indigenous Health Project Officer, GMML
- Deborah Woods, CEO, GRAMS
- Derise Jones, Social Support Unit Manager (former Prison Health Worker), GRAMS
- Gina Lawler, Transitional Manager, Greenough Regional Prison
- Jacki Ward, Senior Project Officer for Returning Home, GMML
- Kate McLeod, Women's Regional Support Officer, Greenough Regional Prison
- Leanne Stewart, Re-entry Link Team Leader, Geraldton Resource Centre
- May Doncon, Mental Health Social Worker, GMML
- Sonya Crane, Social Worker for Returning Home, GRAMS
- Sue Andrews, A/Manager Women's Services, Greenough Regional Prison



Appendix 3: Interview guide

Introduction

- Muru Marri, who we are and what we do
- Your organisation/service and your role
 - What does your organisation/service do?
 - How does your organisation/service contribute with women returning home from prison? What is your role?

Returning Home project

- What outcomes would you like to see for women returning home from prison? Can you describe your ideal scenario?
- What is your understanding about the Returning Home project?
- What is your role with Returning Home?
- What do you hope for Returning Home to achieve in your area?
- What have been your experiences with Returning Home so far?
- What have been the main achievements and challenges?
- What are your expectations for the next few months?

Other matters

- Other items of interest
- Next steps, thanks and closing





Appendix A2. Case study report for Townsville site



Returning Home, Back to Community from Custodial Care

First Year Pilot Project

Evaluation Report for Townsville site

August 2014

This case study was conducted as a partnership between:

The Townsville Mackay Medicare Local Managers and Returning Home to Community from Custodial Care Team who created, nurtured and delivered the Project

Tonya Grant, Indigenous Advisor Programs Manager, Joanne Bourne, RHCCC Coordinator, Bianca Brackenridge RHCCC Project Officer and Carl Grant General Manager Indigenous Programs



and the Evaluation Team

Muru Marri, School of Public Health and Community Medicine
University of New South Wales
Sydney, NSW

Melissa Haswell, Kimina Andersen and Megan Williams

With funding provided by:

Department of Health
Commonwealth Government
Canberra, Australian Capital Territory





The RHCCC Logo was designed by Joanne Bourne in collaboration with TMML Digital Design and Communication Officer. *The circle represents women coming from their community in a whirlwind of circumstances, which has led them to incarceration at the Townsville Women’s Correctional Centre. Dots represented on the trunk of the waterspout shows the different Aboriginal and Torres Strait Islander women, their cultures and skin groups. As they journey through correctional care and are given the opportunity to participate in the Bindal Sharks Leadership Program through the RHCCC Program, waterspouts within their own lives begin to erupt through a self reflective journey and healing happens, bringing tears of sorrow and tears of joy. The women then find ‘the real them’ and their identity as Aboriginal and/or Torres Strait Islander women. The women then begin their journey back to their community with the blue dots representing their ongoing healing that continues back on country helping them to reunite with their land, culture and family.*



Acknowledgements

In the spirit of respect, we acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia.

This work was done on the Lands of the Birri-Gubba Wulgurukaba and Bindal Peoples. These peoples are and always will remain the traditional owners of the land that is known today as Townsville and surrounding communities.

This case study, which is part of a national pilot project funded by the Department of Health, aimed to produce a mutually useful product that reflects the knowledge and experience and community connections of the program developers, deliverers and evaluators. The partners—Muru Marri and Townsville-Mackay Medicare Local and stakeholders—share a common goal; that the story that has emerged can be of local benefit and also inform and inspire other programs for Aboriginal and Torres Strait Islander women going back to community after a custodial sentence.

Special thanks goes to Joanne Bourne and Bianca Brackenridge (Returning Home Team, Townsville Mackay Medicare Local) for organising stakeholder interviews and activities of our visit, and to the TMML Managers and Returning Home stakeholders who gave their time generously to ensure the team gained a clear understanding of the strengths and challenges faced in their efforts to develop a model of care for Aboriginal women. Their trust and openness reflect a willingness to share their knowledge to help other programs become more effective, culturally safe and sustainable in the future.

This case study was made possible by funding from the Department of Health (DoH). We also acknowledge contributions of the Muru Marri team for their input and support.

Acronyms

DoH	Department of Health
MOU	Memorandum of Understanding
NAIDOC	National Aboriginal and Islander Day of Celebration
PCEHR	Personally Controlled Electronic Health Record
ORS	Offender Reintegration Service
RHCCC	Returning Home to Community from Custodial Care
SPRINT	Services and Primary health care needs for Recently Released Inmates in Need of Treatment and health management
TMML	Townsville-Mackay Medicare Local
TWCC	Townsville Women's Correctional Centre



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Prologue: Introduction to Returning Home

Returning Home, Back to the Community from Custodial Care (henceforth Returning Home) is a national project funded by the Commonwealth Department of Health. The project aims to develop effective models of care that will enhance the health and wellbeing outcomes of Aboriginal and Torres Strait Islander women who are returning to the community from prison. The first year pilot project has been implemented at three sites around the country: Townsville Mackay Medicare Local in Townsville, Queensland; Goldfields-Midwest Medicare Local in Geraldton, Western Australia and the Aboriginal Medical Service Western Sydney in New South Wales.

Muru Marri, an academic unit of the School of Public Health and Community Medicine at UNSW Australia, was commissioned to undertake an evaluation of the pilot project, including a case study documentation process that tells the story of the progression of plans at each location—from the initial ideas to the final model of care. This report documents the people and processes involved, the challenges encountered, the model developed and the lessons learned in Townsville, North Queensland.

Returning Home, itself, emerged from the Services and Primary health care needs for Recently released Inmates in Need of Treatment and health management (SPRINT) project, which sought to provide a culturally-specific understanding of how primary health care services can improve health care and social support for Aboriginal people in contact with the criminal justice system and transitioning back into the community. The necessity for a wholistic and integrated case management approach was highlighted. Returning Home gave the opportunity for Medicare Locals and Aboriginal Medical Services, working with other health and community service providers in diverse regions of Australia, to create and implement a culturally and locally-appropriate model that incorporated such an approach.



Executive summary

It is well known that Aboriginal and Torres Strait Islander women who are returning home after serving a custodial sentence face enormous challenges including multiple long-standing health and wellbeing issues, which, like their incarceration, stem from the devastating loss of land, culture and family caused by colonisation and the social, economic and educational disadvantage that continues today. Resulting mental health and substance abuse issues heighten these challenges. In order to properly address these situations, it is necessary to provide access to locally coordinated, culturally appropriate programs targeted to Aboriginal and Torres Strait Islander women that are based on a wholistic throughcare model and incorporate reception planning, case management coordination, transitional programs and primary health care and mental health support.

The Returning Home pilot project, funded by the Commonwealth Department of Health, was designed to build an improved understanding of the most appropriate model of care that Aboriginal and Torres Strait Islander women can expect from community-based service providers who are focused on improving their health outcomes, especially those related to primary health care and mental health.

The Townsville model demonstrates the feasibility and value of a locally-culturally appropriate, wholistic and strengths-based approach, firmly resting on community connections, relationship building and the empowerment of women through leadership training as a key starting point. This prepares women well to take maximum advantage of engaging in the RH Program opportunities for reintegration support through case management and attending Yarning Circles, and the formalized networks offering inter-agency and multi-sectoral support – meeting them inside and easing their access once release.

Despite the RHCCC Programs very short time in operation, levels of appreciation, respect, engagement and recognition of the RHCCC team and its capacity, skill and understanding of what is needed was high among stakeholders. The quality and depth of this program were examined using a research-based critical success factor framework for social and emotional wellbeing that revealed a high level of adherence of factors linked to effectiveness and capacity to be sustained over time. Many important lessons learned in the TMML-RHCCC experience – most importantly that better outcomes for Aboriginal and/or Torres Strait Islander women returning back to their community from custodial care are certainly feasible and the ways to achieve this are already known.



The authors recommend that funding be made available for the continuation of the TMML-RHCC Program, conclude that the team and its model of care are ideally suited for the challenges faced and that a formal impact and outcome evaluation, with a cost-benefit analysis incorporated, based on the proposed framework and measures, commence immediately to measure the effectiveness and economic value of this excellent program.

Townsville is a large regional centre in North Queensland, with one of the two Correctional Centres for women in Queensland. The Townsville Mackay Medicare Local was selected to undertake a pilot program for the Returning Home Project. Despite being a short-term developmental pilot, the Returning Home team at TMML was able to *create and implement a successful, complex and wholistic pathway of care for a total of 126 women within one year*. This case study describes the development, implementation and quality analysis of this care pathway ascertained via in-depth interviews and document analysis.

The TMML-RHCCC Project is an example of what can happen when the right Aboriginal and Torres Strait Islander workers, selected and supported by Aboriginal and Torres Strait Islander managers (bottom up approach) and respectful and flexible systems, with strong connections to community with the right stakeholders at the right time can create and implement a successful model of care in a very short time, despite significant challenges in a highly sensitive area. Besides documenting these successes, this case study sought to capture the subtle but vital critical ingredients that serve as hallmarks of its effectiveness.

While having reservations regarding the short-term nature of the RHCCC pilot program, the TMML Aboriginal Programs manager embraced the opportunity to extend their organisation's developing interest in supporting improved access to healthcare in the local prison. At her recommendation, two Aboriginal female workers with complementary skills, experience and community connections were recruited. Aboriginal and Torres Strait Islander heritage, personal and professional capacity and commitment were seen as essential criteria for being able to meet the challenges of the task quickly.

Systematic development efforts by the Team, supported by their managers, then commenced to maximize existing strengths and networks, notably integrating an innovative case management approach with the successful Bindal Sharks Leadership Program already developed and implemented twice at the Townsville Women's Correctional Centre (TWCC) by a respected Traditional Owner, Bindal Elder, Community Leader and CEO of Bindal Sharks United. Bindal had gained strong support from the TWCC to deliver the Program, and TWCC strongly supported its extension through RHCCC. Attendance of the TMML-RHCCC team members in the Bindal Leadership Program was a vital step



in establishing connection and building relationships with the inmates as participants sitting alongside and supporting them through self-discovery using strategies of self-reflection. This connection enabled TMML-RHCCC to integrate an empowering capacity building experience (the Bindal Leadership Program), with individual case management support through the development of pre-post release transition plans.

The Returning Home Program connection continued with the facilitation of face-to-face Yarning Circles, which provided opportunities for key stakeholders to enhance service awareness and establish referral pathways. The RH team also facilitated information sessions and enrollment for a Personally Controlled Electronic Health Record system – all while inside. As the Project Officer confidently continued client interactions and case management activities, the RHCCC Program Coordinator focused increasingly on key stakeholder communications, commitment, drafting and finalising Memoranda of Understanding with many key service providers. These included Townsville Recovery Centre, Aboriginal Hostels Ltd, TWCC and Queensland Health. The Coordinator also established broader networks and referral systems with primary health care and social services in rural and remote communities beyond Townsville, e.g. Torres Strait to Rockhampton, west to Mount Isa and north to the Gulf where the women returned to post-release. This large geographical extension beyond the TMML service delivery area was supported by the TMML - Close The Gap Managers.

Background

Aboriginal and Torres Strait Islander women who are returning home after serving a custodial sentence face enormous challenges. Many are burdened by multiple long-standing health and wellbeing issues, which, like their incarceration, stem from the devastating loss of land, culture and family caused by colonisation and the social, economic and educational disadvantage that continues today. Health problems include substance misuse, mental disorders, blood-borne viruses (Hepatitis A and B) and chronic diseases such as diabetes and cardiovascular disease.

A recent report by Queensland Forensic Mental Health Service (Heffernan, Andersen & Dev, 2012) called “Inside Out: the mental health of Aboriginal and Torres Strait Islander people in custody” highlighted the multiple mental health challenges faced by Indigenous Queenslanders serving a jail sentence. Of the total 88 identified Indigenous women incarcerated at the time of study, 72 participated. Their average age was 29.1 years and 64% had completed Year 9



education or less and 86% gained income through Centrelink. Nearly three quarters had been incarcerated previously, with 25% experiencing more than 5 episodes, most often with sentences less than 6 months.

The study employed CIDI-A to reveal an enormous mental health burden experienced by the women, with 86.1% reporting a mental disorder in the previous 12 months. For 69.2%, this was a substance use disorder, 50% anxiety and 25% had experienced psychotic illness at a rate more than 50 times higher than the general Australian population. Among anxiety disorders, post-traumatic stress disorder (PTSD), a highly debilitating and distressing long-term condition, had been experienced by nearly one third of the women (Heffernan, Andersen & Dev, 2008). One half had experienced suicidal thoughts and one third had attempted suicide at some time in their life. Many deeply grieve the separation from their children and families, and long for a happy and stable home and life (SPRINT Project Team, 2013).

Reintegrating into society after an incarceration is difficult for anyone, as there are many challenges that need to be quickly and successfully negotiated. Social and formal support plays a vital role in facilitating this transition. The burden carried by Aboriginal and Torres Strait Islander women briefly described above makes it even harder to deal with all of the requirements of returning to their home, meeting their basic social, emotional and physical needs and re-establishing roles and relationships with their families and communities (SPRINT Project Team, 2013). Cultural, spiritual and community reconnection, which is so important for these women, can be very difficult at this sensitive time.

A comprehensive study called SPRINT (Services and Primary health care needs for Recently Released Inmates in Need of Treatment and health management) concluded that in order to properly address these issues, Aboriginal and Torres Strait Islander women must have access to coordinated and culturally-appropriate programs that are based on a wholistic throughcare model and incorporate reception planning, case management, transitional programs and mental health support. Linking the women with safe and secure housing as well as with primary health care and community services is fundamental to ensuring positive outcomes.

Provision of support structures that enable re-engagement with a comprehensive range of services and employment opportunities offers the best chance for not returning to custodial care (SPRINT Project Team, 2013).



Project aims

The Returning Home pilot project was designed to gain understanding of the most appropriate and feasible model of care that Aboriginal and Torres Strait Islander women can expect from community-based service providers. It focuses on improving health outcomes, especially those related to mental health and access to primary health care, which in turn strengthen capacity to maintain positive life direction. The Returning Home evaluation team was tasked with identifying the best approach in primary health care service delivery that enables improved transition arrangements for this client group; and the learnings that can lead to developing a model of care arrangement for the wider cohort of post-custodial care clients.

The service agreement between the Department and TMML, described the project aim as:

“to provide support to Aboriginal and Torres Strait Islander women returning back into the community from their recent custodial sentence. This includes providing culturally appropriate support and guidance to enable engagement and connection with relevant service providers in the area of primary health care (including AMS providers), mental health services, family support officers, women health and wellbeing providers. Importantly there is a need to link health care service outcomes during custodial care to ongoing primary health care in the community. Finally the clients should be enrolled in Personally Controlled Electronic Health Record (PCEHR) program.”

Project Setting

The Townsville Mackay Medicare Local region covers an area from Kennedy to Dysart, west to Richmond and includes Palm Island and Charters Towers.

TMML region, Northern, Central, North West and Gulf areas of Queensland, cover an area of 239,180 km², representing 3.1% of Australia’s landmass. Townsville on the North Queensland coast is the largest regional centre and is the fastest growing region in the state. A number of towns dot the coast, while the western and Gulf areas inland are sparsely populated.

The TMML catchment area includes 421,859 residents (9.1% of the states population)⁵. Queensland Health shares responsibility for primary health care

⁵ Townsville Mackay Medical Local Whole of Region Needs Assessment 2013-2014.
[https://www.tmml.com.au/assets/files/Population-Health/Townsville-Mackay%20Medicare%20Local%20Whole%20of%20Region%20Needs%20Assessment%202012-2013%20Final3%20\(WEb\).pdf](https://www.tmml.com.au/assets/files/Population-Health/Townsville-Mackay%20Medicare%20Local%20Whole%20of%20Region%20Needs%20Assessment%202012-2013%20Final3%20(WEb).pdf)



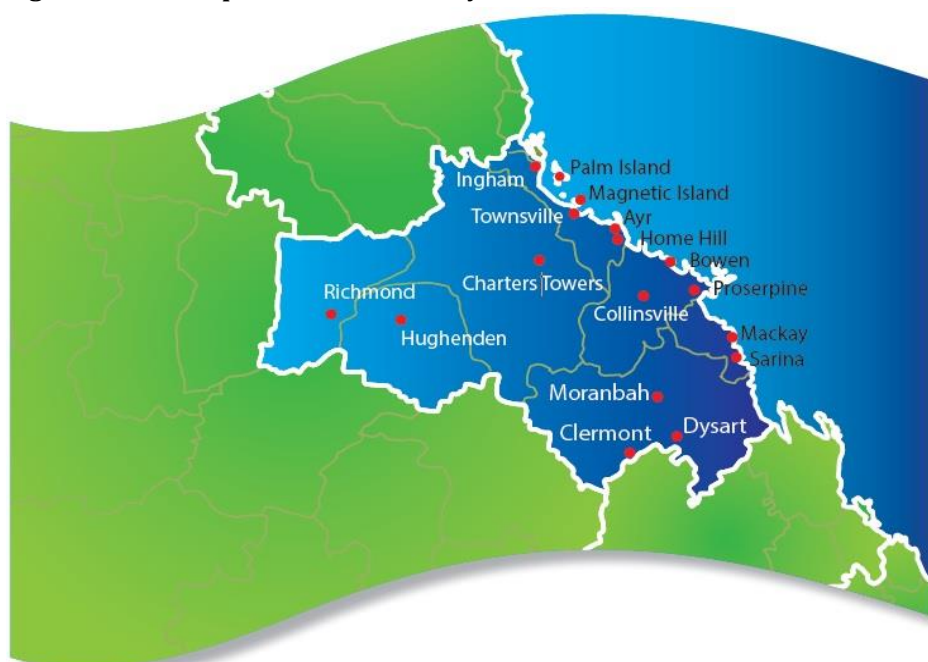
with Aboriginal Medical Services in Bowen, Townsville and Mackay, general practitioners and the Rural Primary Health Care Services.

Approximately 22,420 (5.8%) of these residents identify as Aboriginal and/or Torres Strait Islander. Just over half live in Townsville and Mackay, just under half live in small regional towns and nearly 10% live in the Aboriginal community of Palm Island where about 93.4% are Indigenous. The region is home to over 6,000 Torres Strait Islander people, including some who also identify as Aboriginal and/or South Sea Islander.

The overall health status of Aboriginal and Torres Strait Islander people of the Townsville-Mackay region is comparatively poor and a large proportion experience limited access to health care, especially mental health care and particularly for those living in small remote communities, where all types of specialist services are sparse.

Townsville-Mackay Medicare Local

Figure 1: Area map Townsville-Mackay Medicare Local.



Taken from Townsville-Mackay Medicare Local Whole of Region Needs Assessment 2014⁶.

TMML provides additional strategic support in a number of identified Primary Health Care areas with a focus on improving outcomes. It operates with strong

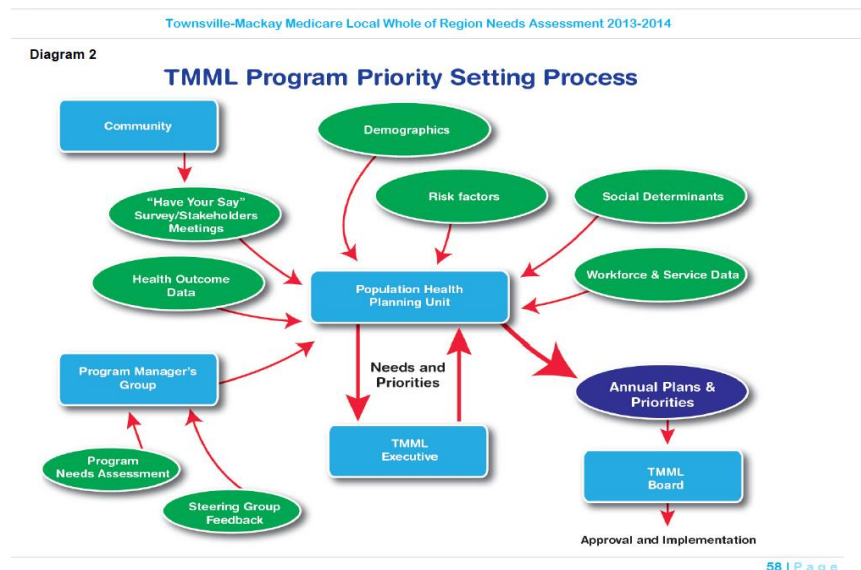
⁶ Townsville Mackay Medical Local Whole of Region Needs Assessment 2013-2014.
[https://www.tmmml.com.au/assets/files/Population-Health/Townsville-Mackay%20Medicare%20Local%20Whole%20of%20Region%20Needs%20Assessment%202012-2013%20Final3%20\(WEB\).pdf](https://www.tmmml.com.au/assets/files/Population-Health/Townsville-Mackay%20Medicare%20Local%20Whole%20of%20Region%20Needs%20Assessment%202012-2013%20Final3%20(WEB).pdf)



population health focus and public health expertise, using both population health data and extensive consultation networks to identify needs, priorities and actions to address these in collaboration with other health care providers. The TMML considers health promotion, prevention of risk factors, community and service engagement, improvement of the social determinants of health and use of data to guide practice as crucial approaches to improving population health.

This focus is demonstrated through its Program Priority Setting Process pictured below.

Figure 2: TMML Program Priority Setting Process



Taken from Townsville-Mackay Medicare Local Whole of Region Needs Assessment 20147.

The Department of Justice and Attorney-General (2010) reports that Townsville has two high security correctional centres for men and women. Townsville Women's Correctional Centre (TWCC) is one of two stand-alone women's correctional facilities in Queensland. Its current premises, opened in 2008, can accommodate 154 women, with 64 in secure cells and 90 in residential units. The Centre also has a specialist mothers and babies unit that can accommodate up to 8 mothers and babies, although there are no additional maternal and child health services provided. There is also a low security women's work camp and farm in the nearby town of Bowen.

In July 2013, TWCC reported that approximately 102 of the total 157 women in TWCC (65%) identified as Aboriginal and/or Torres Strait Islander⁸. Between 13

⁷ Townsville Mackay Medical Local Whole of Region Needs Assessment 2013-2014. [https://www.tmml.com.au/assets/files/Population-Health/Townsville-Mackay%20Medicare%20Local%20Whole%20of%20Region%20Needs%20Assessment%202012-2013%20Final3%20\(WEB\).pdf](https://www.tmml.com.au/assets/files/Population-Health/Townsville-Mackay%20Medicare%20Local%20Whole%20of%20Region%20Needs%20Assessment%202012-2013%20Final3%20(WEB).pdf)

⁸ Statistics from *Townsville-Mackay Medicare Local Returning Home to Community from Custodial Care Project Plan and Needs Assessment*, 2013, citing data provided by email from T. Humphreys



and 21 Aboriginal and/or Torres Strait Islander women were discharged monthly over a 12 month period from 2012/2013, representing over half (53%) of all women discharged. The majority came from Townsville and Far North Queensland, with some from the Northwest and Central regions. This is an enormous geographical area, substantially larger than the TMML service delivery area.

Evaluation Approach and Methods

Identifying the most productive approach

Given the confidence, competence and obvious progress being made by the TMML-RHCCC team in their development and implementation process, and the completeness of their progress report documentation, the evaluation team considered that the TMML team was already using extensive critical and analytical thinking and reflecting continuously on the work they were conducting. The case study approach adopted focused mainly on documentation of the complexity of the program and its developmental process and on providing advice and support in quality evaluation.

The evaluators recognised fairly quickly that the TMML-RHCCC team had not only planned and developed a model of care; they had also accomplished a substantial level of program implementation in the short period. It was recognised that the greatest benefit for both TMML-RHCCC team and the overall project would be to document the model of care and its learnings as a formative evaluation process, and also to conduct and report on a detailed, thorough examination of the quality and cultural competency of the program that was underway. This suggestion was welcomed during the data collection visit to TMML-RHCCC.

Purpose and process of the cultural competency assessment

A cultural lens is required when examining aspects of Aboriginal and Torres Strait Islander programs that underpin cultural safety, engagement, change processes and enhancement of social and emotional wellbeing. If the complexities of relationships, structures and difference are not addressed in this process, it can devalue and potentially cause harm to programs, communities and individuals.

Importantly, the evaluation team was comprised of three workers – a highly experienced Aboriginal and Torres Strait Islander forensic mental health researcher, an Aboriginal lecturer with extensive research experience in post-

from Department of Corrective Services, August 29 2013.



release care and a non-Indigenous academic who had worked many years with an Aboriginal team in Aboriginal empowerment, mental health and social and emotional wellbeing research. The team is clearly aware of the distinct characteristics of Aboriginal and Torres Strait Islander led programs that are linked to success.

Data collection and sources

Data was collected through RHCCC teleconferences, focus groups with teams, in-depth interviews with individuals and program documentation.

Appendix 2 contains a list of people and organisations consulted. These included staff from TMML, Townsville Women's Correctional Centre Department of Corrective Services, and Bindal Sharks United. Two extended focus group sessions, lasting a total of 5 hours, with the TMML Indigenous Managers and the RHCCC staff were transcribed verbatim to enable detailed analysis of the complex program's development, design, delivery, quality and learnings.

A DVD is currently being developed by the TMML-RHCCC team following filming that shares participating women's experiences of the RHCCC program, but this was not yet available at the time of this evaluation report and will be presented to the team when available.

The documents reviewed included the TMML Returning Home proposal, needs assessment and progress reports, a set of templates, program brochures and information sheets used within the RHCCC program; internet pages on the Bindal Sharks National Leadership Program, the TMML Whole of Region Needs Assessment 2013-2014 and miscellaneous brochures.



Project Implementation

Timeline

The key activities that were undertaken during the lifetime of the project are outlined in Table 1.

Table 1: Key Project Activities

Month	Activities
June 2013	<ul style="list-style-type: none"> • TMML invited by DOHA to conduct RHCCC pilot project
Aug 2013	<ul style="list-style-type: none"> • TMML Indigenous Program Manager consulted Community Elder (Bindal Sharks United) • Decision to accept invitation • Project Plan submitted to the Department of Health (DoH)
Sep 2013	<ul style="list-style-type: none"> • Needs assessment completed and report submitted to DoH • RHCCC Coordinator commenced employment • National meeting with all project sites, Canberra 13th September • Work instructions for the program developed • Application for Approval to Work in the Prison Setting submitted
Oct 2013	<ul style="list-style-type: none"> • Brochure, Logo and program story developed • Cultural Awareness Training completed • Safety Induction Training completed by the Program Coordinator
Nov 2013	<ul style="list-style-type: none"> • Second RHCCC Project Officer commenced employment • First national teleconference with all sites, 1 November • Both Project Coordinator and Officer received clearance to work in the Prison • RHCCC Staff attended a Suicide Prevention Workshop • First engagement with TWCC • RHCCC Coordinator developed Yarning Circle Framework • RHCCC Staff attended Qld Indigenous Family Violence Workshop • RHCCC contracted Bindal Sharks to deliver Bindal Leadership Program • Project Officer completed Safety Induction Training
Dec 2013	<ul style="list-style-type: none"> • Progress report submitted to DOH • RHCCC Coordinator attended meeting with ACCHS: Northern ATSI Health Alliance in Cairns • RHCCC Staff attended Personally Controlled Electronic Health Record training • First Bindal Leadership Program commenced
Jan 2014	<ul style="list-style-type: none"> • Second national teleconference with all sites, 28 January • RHCCC staff & TMML CTG General Manager presented project at the Palm Island Council Meeting • Submitted 6 monthly report to Dept of Health • Graduation held for Bindal Leadership Program 1
Feb 2014	<ul style="list-style-type: none"> • RHCCC staff attended TMML Public Speaking In-service • RHCCC Program/Bindal Sharks delivered 2nd Bindal Leadership Program • RHCCC Coordinator developed Media Release for distribution within TWCC regional area • Yarning Circles facilitated by RHCCC staff • 1st Meeting with Jepson Media re: RHCCC Program Evaluation DVD



Table 1: Key Project Activities, continued

Month	Activities
April 2014	<ul style="list-style-type: none"> • Evaluation visit by Muru Marri • RHCCC staff attended TMML Public Speaking Inservice • RHCCC Coordinator attended training in responding effectively to behaviours of concern
May 2014	<ul style="list-style-type: none"> • Discussions with Muru Marri about the possible use of the GEM • RHCCC Coordinator completed work instructions for Accreditation • RHCCC Staff attended Customer Service Training
June 2014	<ul style="list-style-type: none"> • RHCCC Program contracted Bindal Sharks to deliver trial Men's Leadership Program at Townsville Low/Open Farm Facility (TCC) • RHCCC Staff invited to TWCC NAIDOC Committee Meeting • RHCCC Staff attended 'What's up with my Mob' (trans-generational trauma, lateral violence and cultural loads) • RHCCC Staff & clients filming of Evaluation DVD • RHCCC (draft) Final Report ongoing
July 2014	<ul style="list-style-type: none"> • Graduation Bindal Leadership Program 2 • Filming of women's stories for DVD completed • Funding completed, project ended • 2nd meeting with Jepson Media re: Evaluation DVD • RHCCC Staff presented informational stall at Townsville NAIDOC Day • RHCCC (draft) Final Report ongoing
August 2014	<ul style="list-style-type: none"> • Draft case study report submitted to TMML • Final case study report approved for inclusion in TMML Report • RHCCC Final Report & Evaluation DVD completed and submitted to TMML CEO
September 2014	<ul style="list-style-type: none"> • TMML to submit its final report to DoH

It is clear from Table 1 that the two RHCCC staff members were extremely active throughout the year of operation. Substantial training/upskilling opportunities were taken throughout the period, ensuring that the RHCCC was knowledgeable and prepared to confront challenges raised by the women, such as domestic violence, suicidal thoughts and behaviours of concern. Staff participation in NAIDOC events, development of the project logo and story, and attendance at the Bindal Leadership Program would have demonstrated to their clients a clear commitment to cultural values.

In between these key project activities of the RHCCC staff were several hundred (495) case management service episodes with the 126 participating women, frequent Yarning Circles, and many telephone, email and face-to-face meetings (321) with key stakeholders to establish, develop and finalize optimum referral pathways, with six of these formalized through signed MOUs.



The following sections detail this developmental process and the activities established to create a wholistic model of throughcare, and the learnings that emerged.

Laying the Essential Groundwork

1. Decision to proceed and establishing the Program within TMML

Considering whether it “fits in” and engaging Indigenous Manager in the decision

The decision by TMML to accept the offer from Department of Health to become a site for the Returning Home project occurred after brief, but in depth consideration. While TMML always welcomes opportunities for additional funding, the very tight timeframes for preparation and the short time of guaranteed funding were significant concerns. A meeting was held within TMML, as Indigenous Advisor Program Manager at TMML, explains:

I remember being brought into that room to discuss whether there was the potential for us to take that project on, given the limited time, it was only a year... My only concern was the sustainability of any work that was done... .

Important to that decision was the fact that there were already plans and activities within TMML to introduce an ear health program in the prison. The RHCCC program gave an opportunity for the organisation to add to its knowledge and expertise in linking people to primary health care services and chronic disease management in a very important setting. Thus the RHCCC program fit in well with existing work and emerging interests.

Engagement with Traditional Owners, Elders, community

The Indigenous Advisor Programs Manager made sure before pushing ahead that she engaged with the community right from the beginning as an essential step for assisting sustainability:

Anybody can apply to go and get funding to set up something, but if you don't have community voice in that from the beginning [its not sustainable], one of the things I did do is I went and talked to Auntie Jenny Pryor [Bindal Elder/Community Leader] about it because she was out there doing the Women's Bindal Leadership Program, and I asked her what the issues were.

This engagement embedded in a long-standing respectful mentoring relationship between the Bindal Elder and the Manager, established a community connection for RHCCC from its conception. The support, advice and collaboration given by the Bindal Elder at that time and continually over time was also crucial for the success of the program.



Careful consideration of the benefits and risks involved

From the discussion with the Bindal Elder, it became clear to Indigenous Advisor Program Manager that TMML was prepared and able to meet the expectations of the Returning Home project. The perception was that the pilot was a trial, and that continuity in funding was possible if success was achieved, not only in developing an excellent model of care, but also in being able to “*sell the message of what has actually happened*” and the value of the service in helping the women move forward into a better life.

The greatest recognised risk was not failure to plan and create an excellent program, rather it was the potential loss of the excellent program if funding was not continued. It is a very common, universally shared frustration for Aboriginal projects that start up as a pilot, show success, but are not provided with funding to continue a long term.

All parties felt a responsibility to ensure that all parties recognised that there was no guarantee of program longevity; and took steps at all times to only make commitments that they knew could be fulfilled and avoid raising false expectations.

2. Identifying required skills, abilities and personal qualities of staff

Of prime identified importance, discussed from the beginning of the program’s conception and the initial engagement with the Bindal Elder, was the need to recruit the right people to build the program and to create a culturally appropriate mentoring structure to nurture their development and support their progress. The structure successfully created for TMML-RHCCC involved one Aboriginal Community Elder, two Aboriginal program managers, and two Aboriginal and Torres Strait Islander staff.

A strong preference for Aboriginal and Torres Strait Islander workers within that structure was clear for many reasons. Having both formal and informal networks was seen as critically important, as explained by the Indigenous Advisor Program Manager:

It seemed to me straight away that it has to be someone who had a lot of connections... from Rockhampton right up to the Torres out west to Mt Isa... a lot of times when organisations employ Indigenous people they don’t realize that what they’re getting is both the formal networks that person has, and you’re also getting the informal networks... a lot of the time we use the informal networks to help us do our job because you’ve got to pull that stuff together.



For RHCCC and its tight timeframe within which to demonstrate success, having well connected Indigenous staff was seen as essential:

I think if you get someone that's not Indigenous, sometimes they are not going to have those networks. So it might take them 3 to 6 months just to get an idea of what the role is and then they go and engage with community.

The interviews revealed many more reasons why Aboriginal and/or Torres Strait Islander heritage and being female were seen to provide additional enormous benefits. Because of the cultural connection, women opened up very quickly, felt safe and understood and they didn't have to explain their worries about their community in detail. The social and emotional vulnerability of many of the women, often associated with traumatic experiences with men, requires enormous sensitivity. Thus meaningful engagement requires a high level of trust and respect facilitated through shared cultural connection without gender barriers. The Bindal Leadership Program (described below) gave an opportunity for women to participate in a self-reflective journey to address the trauma and challenges in their lives within a culturally safe and appropriate environment.

As explained by the Indigenous Advisor Program Manager:

The underlying issue is that connection. You can't achieve anything without being able to connect with these women at that deeper personal level. If you connect, you're fine after that. That rapport, they start to let you in, they've built that special bond with you... it needs to be Indigenous women connecting with Indigenous women at that deeper, spiritual level that is difficult to explain. And once that connection is done, then word spreads.

Outside the prison, cultural brokerage – easily communicating with councils and services in regional and remote communities is also essential – and being an Indigenous person with family and cultural connections often makes this work much more effectively.

3. Recruiting and supporting the team

The team and structure possessed a complementary range of skills, experience and connections. The Indigenous Advisor Programs Manager had extensive experience in the prison system as an Education Officer. This experience demonstrated to her that success in reintegration is achievable through listening and helping people recognize the pathways that are possible for them, sharing stories of others' success in overcoming the many barriers through education and pushing achievements back to them to build self-trust and ownership of the positive outcomes of their choices and efforts. This hands-on style of working was also evident in her approach to management – recognizing needs for the



project, providing strengths-based assistance to the team and advocating for their needs to allow them to carry out the best possible job.

Her previous corrective services work and many other professional and personal experiences gave the Indigenous Advisor Program Manager clear recognition of the qualities needed in the staff to undertake the RHCCC project. In addition to traditional selection criteria for the Coordinator position, the prime skills and abilities sought were formal and informal local and regional networks, skills to make connections and develop positive and productive relationships very quickly, persistence and a high level of commitment, energy and professionalism.

Having the ability to network quickly, because you don't want to put someone on who you have to train to get them up to speed to understand... so I fought for someone of that caliber (JB) to make sure we had those networks in place.

The successful candidate (JB) clearly brought to the RHCCC Programs extensive hands-on experience and skills developed as a workforce consultant with Health & Community Services Workforce Council and the Workforce Development Officer with the Queensland Aboriginal and Islander Health Council across 52 Aboriginal Medical Services in Queensland. She carried into RHCCC a broad network as well as an in-depth understanding of how to link and motivate organisations to enter into MOUs and work together effectively towards common goals. She also worked in maternal health, within the TMML Bubba's Business - Family Kin-ect Program that supported pregnant women and mothers outside of Townsville during and after birth and connected them with services as needed. The depth of understanding of services and people, combined with her persistence, genuine and caring nature and humour, nurtured through mentoring from the two Indigenous Managers (a second joined TMML during the project) and the Bindal Elder/Community Leader, no doubt drove RHCCC's many successful linkages described below.

While the Project Coordinator brought extensive experience mainly in health services and workforce development, the recruited Project Officer for RHCCC brought other highly complementary experience, skills and personal strengths. The Project Officer had worked for several years with Centrelink and in community youth programs, concentrating on linking young boys from custodial care to education, social services and employment opportunities. Her empathy, listening skills and ability working one-on-one made her ideally suited to case management work. Through experience within the Women's Bindal Leadership Program and mentoring support, the Project Officer progressively took over the face-to-face engagement and case management component of the RHCCC, and increasingly managed RHCCC's relationship with the Corrective Services staff. This enabled the Program Coordinator to focus increasingly on securing strong



service linkages and activities outside the prison and continued communications with TWCC Management.

Mentoring provided a crucial role with the TMML-RHCCC, enabling the two RHCCC staff to undertake the many roles they played at a highly competent level. References to the importance of the continuing guidance and support from the Bindal Elder/Community Leader to both managers and to the RHCCC team, as well as between the managers and the team.

Furthermore, the strong advocacy role played by the TMML Indigenous Advisor Programs Managers for the staff and RHCCC program was hugely appreciated and highly motivating for the team. Their support also gave assurance that they were in a culturally safe working environment. This essential input occurred in the selection of the team, in ensuring that they are recognised for *their expertise, cultural brokerage and benefits for the organisation* and in ongoing support within the TMML. This created a very solid working unit highly focused on achieving the best for the women returning home and simultaneously developing their own capacities.

4. Proposal and Needs Assessment

The TMML-RHCCC Project Plan and Needs Assessment, submitted to DoH in September 2013, identified the following priority areas to enhance health outcomes of Aboriginal and Torres Strait Islander women returning home from custody (verbatim, p 3):

- Access to mental health services (specifically social and emotional wellbeing)
- Lack of contact with family and children (child safety issues)
- Lack of appropriate accommodation
- Access to drug and alcohol services
- Access to employment opportunities
- Support for domestic violence issues
- Access to maternal health services
- Lack of access to local support services when released.

These identified needs emphasising social and emotional wellbeing and mental health, as well as their social determinants, are entirely consistent with the findings of the Outside In report described above (Heffernan, Andersen & Dev, 2008). The need for healing, improvement of underlying social determinants of health, better coordination among health service providers across the region and improved access for Indigenous women to a range of services is clear.



Establishing relationships and partnerships

5. Connecting with Corrective Services

One of the challenges at this site in the RHCCC pilot program was the lack of understanding about the project within the Townsville Women's Correction Centre and its role and hence limited 'buy in' from Corrective Services at the beginning:

The fact that Corrections didn't have any buy in to it was a challenge because they didn't even know who we are or what we're doing. So it took a long time to ...see the value, they didn't really understand... 'what are you guys here for and what's your role, we have a transitions coordinator, I can't understand where you fit'.

Although there were apparently high-level discussions with state representative from different departments in Canberra and in Brisbane, this information did not appear to trickle down locally to the selected Correctional Centres. This caused confusion between the existing Offender Reintegration Support Service (ORSS) and among other services outside of health that increased the challenge for the TMML-RHCCC team to enable a smoother system of collaborative service provision.

As explained by the Indigenous Advisor Program Manager:

If you're going to do policy, there's got to be a sign off from all those different departments who are involved... It's not just prisoner health. Prison health includes Corrections, Justice, Centrelink, all those different areas should be included in that one agreement to make sure we get collaboration across the spectrum...

Despite the absence of clear groundwork at policy and upper management levels, RHCCC team did manage to successfully integrate themselves within the Corrections system. One lever was through the RHCCC's relationship with the Bindal Leadership Program, which the TWCC Director was already highly supportive of. The respectful links that Bindal Elder had nurtured with Corrections facilitated trust and recognition of RHCCC's potential role in adding value to the women after they completed the Bindal Leadership Program. In the focus group with TWCC management, many references were made to the appreciation they felt for the specialized and valuable work provided by the RHCCC staff.

While this facilitated connections and entry approvals relatively quickly, there was a more extensive process required to build positive links with the ORSS Officer – which took many emails, phone calls and conversations over nine



months when RHCCC's complementary, rather than conflicting roles became clear.

Now she [the Offender Reintegration Support Service officer] sees the value, and we see the evidence by the referrals she's starting to send through... thanks for that information, it was really helpful. That's what we're here for... there might be something that we can do as Medicare Local, and if there is, ask, we're happy to help in whatever way... not to try or challenge or take over or duplicate.

The interview with the ORSS officer confirmed this, demonstrating a very positive view of what RHCCC had achieved, and recognition of the importance of their work adding value. Cultural gaps and workplace roles prevented the ORSS officer from providing the kinds of support that the RHCCC was able to bring to the Aboriginal and Torres Strait Islander women and the partnership was highly valued.

Commitment by the RHCCC staff to transparency, honesty, openness and sincerity with the Offender Program Manager, the Transition Coordinator and the Cultural Coordinator regarding referrals and activities is also likely to have promoted good working relationships. This transparency is provided through email correspondence where each party receives copies and also in meetings:

It's about me being accountable for what we do too and to ourselves, and Medicare Local. But most of all its about being accountable to the women. ... As we see the Cultural Coordinator and the Transitions Coordinator, so if she's doing something with that lady in the transition process, she's aware of the information we're sending back through her channels.

As discussed further in section 10, challenges with information sharing regarding release was a barrier preventing greater support by RHCCC to all women upon release.

6. Creating linkages, referral pathways and MOUs with local services

An enormous amount of effort was placed into the development of MOUs with a host of local services who play roles in supporting women post-release. Similarly to the challenges faced with Corrective Services, the absence of high level and mid-level discussion and mutual agreement with the aims of the RHCCC was a barrier to achieving functional working relationships with some of the organisations:

There really needs to be a national policy, ...commitment at all levels, across housing, mental health, primary health care, social services because they're all the people that go in and provide these services in and out.



The Indigenous Advisor Program Manager continued,

There needs to be high level agreement at Cabinet, Minister and Director General level, to get commitment and accountability from all stakeholders to have more formalized integrated coordination across all sectors and improve cross sector collaboration. There is a need to have key identified National and State Performance Indicators for Director Generals to ensure that there is greater integrated coordinated support for women transitioning from prison to community. These same performance indicators need to be incorporated into funding rounds for the types of support services for prisoners with local prisons ensuring that facilitation and coordination of these services are provided for inmates.

RHCCC recognised the need for formalization of cross-organizational partnerships and referral pathway in order to clarify roles and responsibilities and maximize opportunities to provide optimum care. While initially the MOUs were more general, they evolve over time as the complexity of the program increased and the details of the interaction can be clearly specified and work more effectively.

Four advantages of detailed MOUs were described. One was to ensure that staff clearly understand their roles and responsibilities in referral processes so participation is formalized and expected, rather than seen as optional. Secondly, with staff turnover, MOUs provide a clear guide to how these pathways operate, as opposed to only knowing through word of mouth. Thirdly, MOUs can lay out processes of communication and information sharing, facilitating more wholistic care. Finally, MOUs are a statement of commitment and good faith, helping to ensure reliability for the client when referrals are made that partners are focused on her ease of access and her health and wellbeing.

Thus far, TMML-RHCCC had created linkages, referral pathways and MOU processes with TWCC, Townsville Aboriginal and Islander Health Service (AMS), Close the Gap, New Directions Bubba, SOLAS (Supported Options for Lifestyle and Access Services for mental health recovery) and various programs within the Medicare Local.

Initial discussions had occurred with the Community Justice Program to create a referral pathway to RHCCC when women face court ordered parole. This would enable the team to work with the women on health and wellbeing issues in conjunction with the Community Justice team.

It was very clear in the interviews that a particularly important characteristic and/or skill required for formalizing the MOUs with services was to use a patient but persistent approach and described as:



It's easy if you get turned away once to stop asking and give up. [The skill is] how to approach it again and again, same conversation, in different ways, while acknowledging the value of the service. [This process has been boosted by] inviting them as guest speakers at the Yarning Circle.

The RHCCC team recognised that, in order to motivate services to place a priority on their roles in the pathways of care, two conditions needed to be overcome. First, stakeholders needed to understand that RHCCC was completely focused on achieving the best outcomes for the women, and not seeking to threaten, judge or take over the roles of other organisations. Closely related to this was the need to understand and clarify how involvement with RHCCC would assist the service in meeting their own accountabilities – and hence **want** to become involved. Particularly strong examples of that were witnessed with the ORSS Officer and the community mental health service providers from SOLAS.

Developing and implementing the model of care

1. Connecting through the Women's Bindal Leadership Program

The idea of connecting with women through the Women's Bindal Leadership Program arose during consultations taking place at the original conception of the RHCCC in Townsville. The Program was designed, developed and delivered by Bindal Elder/Community Leader Auntie Jenny Pryor and had already been delivered twice in the TWCC. As a result of program's outcomes, the TWCC Director took the initiative to obtain classification of the program as a criminogenic program by Corrections Queensland, meaning that it now must be made available to inmates as part of their routine rehabilitation program. While awaiting the outcome of this classification process, RHCCC was able to contract Auntie Jenny Pryor to deliver the program as an entry point for women into the RHCCC program. Furthermore, the two staff of RHCCC elected to participate in the 28-unit social and emotional wellbeing program, side by side with the women on a healing journey:

...Guiding the woman to go on a journey themselves, developing their own strategies ..., looking at their reintegration and looking at what their support needs and challenges are and looking at the risk management stuff.

Interestingly, the Bindal Leadership Program established a firm rule that all women, Indigenous and non-Indigenous, are welcome, and RHCCC agreed to adopt the same policy. This has not caused resourcing problems in Townsville, since most women are Indigenous and only a small proportion coming forward seeking support are non-Indigenous. The many significant advantages include the fact that any woman needing help is not turned away; it avoids anger and



frustration from non-Indigenous women that want assistance but cannot access it, and the inclusive approach promotes collective wellbeing and enhances support from prison officers. The RHCCC Coordinator explained:

All women are broken and they need healing whether your Aboriginal and Torres Strait Islander or not. So this is the information we can help them with and we help connect them to services that they need connecting to... we can't segregate... it would just cause a riot, 'why are they getting this'... It's great just seeing all the women and they know their support is for all of them.

The staff noted that all components of the RHCCC program were highly appreciated and helpful to non-Indigenous women. The principle of inclusion was highly appreciated by TWCC management and officers. After sharing the experiences of the women in a presentation to 35 TWCC offender program staff, special consideration was granted for access to both the Bindal Leadership Program and the Yarning Circles (described below) by women on remand but not yet sentenced, those on short sentences and all others who were normally excluded from prison programs.

2. Creating safe and supportive Case Management

We thought, what a great idea, the women who go through the Bindal Leadership Program, by the time they come through the fourth week, they've built a good enough rapport with us where they self-refer into our program. We then look at the transition needs, pre and post and develop that.

This integrative and innovative way of thinking, as described by the RHCCC Coordinator, is an example of how opportunities, ideas and commitment led to a rich and valued program as a whole and quality in its mutually reinforcing individual components.

The case management activities were initially undertaken by both RHCCC staff, with increasing responsibility shifted to the Project Officer as her confidence and abilities increased. RHCCC's case management processes provided an individual focus point, usually following one of the two group activities which often served as the entry points, i.e. the Bindal Leadership Program and the Yarning Circles. The Bindal Elder/Community Leader also continually promoted the case management service and encouraged women to sign up and it is likely that positive words spread between the women leading to wider engagement. Furthermore, an Expo activity held at TWCC led to substantial numbers of referrals in.



The procedures of the case management sessions for new referrals include:

1. Completing a Referral Form collecting basic information and identified needs regarding social and emotional wellbeing, primary health care and social services, plus the support being sought by the client from the RHCCC program.
2. Signing a program consent form to allow the RHCCC team to explain the activities of the RHCCC program, invite participation in Yarning Circles and pre and post release support and to provide consent for access to the client's health and social information. A media consent form is also offered at the time to allow photographs to be used to promote the program.
3. Completing a form to register for a Personally Controlled Electronic Health (eHealth) Record to facilitate continuity of care following release. The RHCCC has provided an easier to read information sheet to clarify the purpose and process of being part of the system.
4. Commencing an interview and creating a RHCCC Program Holistic Transition Pre and Post Release Plan, at that time or in the second session.
5. Completing an Action sheet based on the Holistic Transition Plans to list the needs and actions that are required to address them.

These Holistic Transition Plans allow RHCCC to assist women to think through their needs across a range of areas, namely ATODS support, supported accommodation, employment training, mental health support, medical and dental care access, probation and parole to clarify any parole requirements and social services. With this information, RHCCC can facilitate, link and inform the client of the various pathway choices, and also feed into the Yarning Circles regarding needs arising. A copy of the plans is provided to the women to keep as a guide.

The Action Sheets are also forwarded to Corrective Services, including the Transition Coordinator and Manager and the Cultural Coordinator to arrange referrals as needed regarding dental, medical, housing, legal and other needs.

The RHCCC team's wide range of formal and informal networks, some with signed MOUs and clear referral pathways, makes the team an invaluable complementary resource, adding value to the ORSS and Transitions Program in assisting women. This is not only achieved by engaging with women to develop a Holistic Transition Plan, but also to follow through with the referrals that the women feel they want and would benefit from. The Yarning Circles described



below greatly boost this process and breaks down some of the barriers women face in accessing the services after they leave.

A confidential database is used by the RHCCC team to record initial client information and the service provided during these sessions, enabling easy access to progress made in the Transition Planning process. TMML databases Profile and Chilli are used.

Output produced by this database demonstrates that between commencement of case management support in September 2013 up to April 2014, 326 appointments were held with 62 women. The average number of visits was 5.3, with 41 women having 1 to 5 appointments, 13 having 6 to 10 and 8 having over 10. The large number with small numbers of appointments is expected because of the rapid influx of newly registered women at that point in the program. In the final three months of the project (April to June) the number of women doubled to 126, which demonstrates the rapid growth in awareness, popularity and likely high level of satisfaction with the planning service.

3. Holding the Yarning Circles

As women's needs have become clearer through RHCCC's experience in the Bindal Leadership Program and case management, and communications and MOUs with organisations developed, RHCCC established an innovative process called Yarning Circles. The Coordinator explained its origins:

It just started, that's what we do, just what the Murri mob do, ... very first and foremost Bianca realized that we had to connect with the women, we do that first and foremost, we connect through yarning, that's how the yarning circle came about.

These occur two times a week, one day with the women in the secure unit and a second day with the women at the low security farm site. As numbers rose, discussions were occurring to possibly increase to three times a week, with the same guest speaker coming on one day to talk with women in the Secure cells, another day for those in the residential units and a third day with women at the farm. According to the Coordinator, the specific aim of the Yarning Circles is to:

Provide the right information to the women about what they need to help them make better choices about how to self-manage their health. So it's not about a service going 'you need to do abcd', it's about a woman going, 'these are my needs and I can go wherever I choose because I'm more informed about what's out there

While the idea of a Yarning Circle is a very good one, it is particularly in the way they are designed that demonstrates *excellence* as both informative and empowering for the women. Thus rather than the RHCCC team organizing a



series of speakers from services they know, the team instead worked carefully to enable the women to identify what they want to learn, what they need help with and what speakers/services they want to hear from. Both Indigenous and non-Indigenous women attend.

We said to the women, it's about what you think you need, what's going to help you in here, what's going to help you when you get out, what information do you need to make a better choice. This is your yarning circle... if you want it, this is a great opportunity.

In addition, the women designed the event by developing ground rules to ensure safety, respect and maintain a whole group information session, rather than an individual support session. Hence those who want more direct assistance in the area being discussed can request a case management session with the RHCCC to move forward.

We're here to work for the ladies, it's about them, it's not about us.

An evaluation form is provided to participants to collect feedback and ideas for future sessions.

A comprehensive array of service providers have engaged in the Yarning Circles, including Close The Gap, SOLAS (mental health recovery support), New Directions Bubbas Business, Pathways to Employment and Job Readiness, Aboriginal Hostels Inc., Centacare, Headspace, Department of Communities Emergency Rental Assistance Program, and the Transitions Unit of TWCC. The team from SOLAS found the Yarning Circles so valuable that they now come into the prison routinely each fortnight to talk about anxiety, depression and any other areas of interest to the women.

Attendance at the Yarning Circle has been high, initially 17 attended and up to 25. Although initially women came to the Yarning Circle through the Bindal Leadership Program via the case management sessions with RHCCC, the activity has become so successful that increasing numbers of women entered the RHCCC program by registering to attend a Yarning Circle, then receiving follow up support through case management.

They're coming from everywhere now that the word's out.

Besides helping the women, the Yarning Circles appear to have significantly strengthened ties between RHCCC, TWCC and other services due to their popularity and multiple benefits, as mentioned above. This is especially true for TWCC, who has been highly supportive of the activity and facilitated flexibility for the movement of the RHCCC staff in organizing and running them. The Yarning Circles are seen by services as a way to engage with those most likely to



need their support, but least likely to be able to attend due to barriers once released. Although it takes time to get clearance from the authorities to enter the prison, once the process is completed, it becomes easy for service providers to work through the Yarning Circles that are set up by the RHCCC team.

4. Post-release support

Despite improvements in relationships with most of the TWCC staff, especially with high level management, challenges were still being experienced with information sharing. This has prevented RHCCC staff from routinely receiving the list of monthly discharges. Access to that list would have allowed RHCCC to work with the transitions coordinator to comprehensively plan and support each women's release and returning home process. At the time of data collection, RHCCC was working to complete and gain sign off of a detailed MOU with Correctives Services to finely detail the roles and responsibilities of each party in the release of all Aboriginal and Torres Strait Islander women. The hope was that this would ensure that information about release dates each month was provided to RHCCC to act upon.

Another circumstance where RHCCC is held back is in supporting women released on court order parole, which adds an additional complication to being available to provide support at a critical time.

That's probably the biggest barrier for us because Corrections doesn't share a lot of information with us, we hear from the women, we hear from ORSS, other services, if we don't hear that way or from the women, we don't know. So there a lot of women we're missing even though we've got 107 plus 15 more of Friday. And you've got 180 ladies out there.

In the absence of that formal process, informal processes were used in many cases to play a role immediately post release. Many examples were provided during the focus group of how RHCCC's cultural brokerage skills and connections all around North Queensland facilitated women's post-release journeys. This included support during travel, especially in layovers and making bus changes in towns, transportation for women to probation and parole, assurance that women with chronic diseases could access care en route or on return home and facilitate access to bulk billing practices and alcohol and drug services.

Messages back to the RHCCC team have also come through from women post-release through health workers, particularly those wearing the Close the Gap shirt with the same logo as worn by the RHCCC team that the women can recognise. One in particular was a plea for help – *she was about to give up.*



The RHCCC had also been discussing the potential value of a 1-800 freecall number, where women could ring in and the team could immediately ring back. This could overcome challenges with losing the RHCCC number, not having credit or not having a phone.

A particularly innovative and promising development has been the identification of two mentors, one Indigenous and one non-Indigenous, who were long-term inmates that completed the Bindal Leadership Program. These women have been available to listen to and support newly released women who have returned to their communities and need someone to talk to and help them deal with the issues in their lives.

5. Graduation celebrations, campfire meeting and the Evaluation DVD

The TMML-RHCCC team clearly recognises the importance of celebration and providing a space for women to reflect on the growth and achievements they made through involvement in the Bindal Leadership Program and RHCCC program. It is well accepted in adult learning research that reflection, leads to consolidation of learnings, recognition of progress and renewed commitment to using new strengths in future choices and directions (Mezirow, 1990). Collective reflection is practiced with the Bindal Leadership Program, the graduation, and the Yarning Circles.

The two graduations were important events. They provided recognition, acknowledgement and celebration to the women for their achievement and a chance for them to share their journeys of transformation. Both graduations were attended by the TMML Deputy CEO and the two Senior Indigenous Program Managers as well as TWCC Management and the three cultural officers. This created an opportune time where the two organisations could meet, demonstrate their support, hear directly from and celebrate the achievements of the women and the value of the Bindal Leadership and the RHCCC Program.

A campfire meeting was offered to women who had 'returned home' at the very end of the RHCCC Program. This an additional opportunity to reconnect with those who shared their journey, reinvigorate their plans and acknowledge to themselves and others that they are on their way towards a different future. A DVD is being produced that captures the stories of three women who moved from lives of incarceration to lives of possibility and achieving potential and the parallel story of the RHCCC program and its team. Acknowledged by Elders and leaders, the DVD will serve as a tangible reminder to key stakeholders and viewers, including policy makers, of the capacity of women, with the right support at the right time, to heal and move forward. An appropriate dissemination process for the DVD is being planned.



6. Regional services networking

As the catchment area of the Townsville Women's Correctional Centre is vast, most women leave the Centre returning to places outside of Townsville. As explained above, the RHCCC team was not able to secure a formal process of receiving the monthly list of names of women expected to be released and their likely discharge dates and times.

Without this advanced notice, it was difficult for RHCCC to provide immediate support and care for the women they had been working with. Word often came 'through the Murri grapevine', enabling support to be offered around transportation, accommodation and referrals at a time when it may have been most needed. At times this also included onward connections and assistance in bus transfers, overnights, medications and healthcare appointments on the journey home.

Recognising the need to be proactive, the RHCCC team, particularly the Coordinator, increasingly spent time in organizing and convening discussions and meetings with service providers around Queensland. The ultimate goal was to obtain a comprehensive referral network that would be formalized through MOUs to ensure clear and straightforward pathways for women to access once home. The team established and continually built upon a database of services, bus times, resources, contacts, etc. for women going home to places in western, North and Far North Queensland, the Gulf and Mt Isa regions, and coastal towns.

Efforts were also made by the TMML-RHCCC team to increase the visibility of the program through local and regional media and stakeholder newsletters, to prompt and interest services in becoming part of the RHCCC network.

7. Developing framework for program evaluation

TMML-RHCCC had established a number of mechanisms with which to embed in a continuous quality improvement framework and demonstrate their achievements across several areas of the program. They exceeded accountability requirements in this project and sought to put in place both qualitative and quantitative mechanisms to capture progress, program quality and outcomes.

Examples of mechanisms they had already employed:

- Measuring the success of the Yarning Circles, in attendance, active participation and in counting immediate and subsequent referrals to the case management activities that occurred



- Demonstrating numbers of women moving into the program from the various entry points
- Capturing the stories of life changes that were recounted by the Project staff
- Documenting the testimonies of the three women's post-release journeys on the DVD

The TMML-RHCCC team also expressed strong interest in using additional tools and mechanisms to capture the strengths and skills gained through the Bindal Leadership Program and nurtured through the other TMML-RHCCC activities through use of:

- The Growth and Empowerment Measure (Haswell et al., 2010)
- Quality assessment and CQI tools that examine the most important aspects that make the program effective, sustainable, able to grow, e.g. Critical Success Factors
- Health outcomes, education and employment outcomes, justice outcomes following release and returning home
- Cost-benefit analysis
- Monitoring further development of the project should it be enabled to achieve its potential

Unfortunately there was insufficient time to integrate these additional processes to fully quantify the gains in critical areas of empowerment and life trajectory prior to the end of this project because of the ceasing of funding.

Summary of Key Learnings from the TMML-RHCCC Experience

The extraordinary success of the TMML-RHCCC in an extremely short time provides a very important lesson for all who work in this space. The overwhelming lesson is that the provision of life changing support is possible, feasible and inarguably a sensible way forward. The case study also unexpectedly found suggestive evidence that the approach implemented by this tiny Aboriginal team at TMML with its partners can meet the needs of both Indigenous and non-Indigenous women.

The following are key learnings that emerged from the experience of the TMML-RHCCC that have defined both its challenges and achievements over the last 10 months.



Six key learnings about preparing the groundwork

1. High level agreement, commitment, accountability and performance indicators across all the key sectors is vital to success and sustainability of throughcare projects on the ground.

Because of the complexity of challenges that Aboriginal and Torres Strait Islander women carry following discharge from prison, there are many important sectors involved in the provision of services required to assist in their successful return home. The more communication, coordination and share accountability for positive outcomes there is across these sectors, the more likely that women will be benefited and able to make positive choices and changes in their lives.

The most significant barrier experienced by the TMML-RHCCC project was the lack of 'buy in' from most sectors at the beginning of the project. Their role was unclear, and their progress was hampered by middle management not being aware of the project. While the RHCCC staff displayed tremendous capacity to make and grow linkages under these difficult circumstance, this process would have been smoother and quicker if all key sectors were on board and shared accountability for the positive outcomes of Aboriginal and Torres Strait Islander women post-release.

2. It matters how funding decisions are made.

This includes who receives the invitation, how is it communicated to staff within the organisation, who handles the decision-making process, what community engagement processes occur before the decisions and approach is determined, who determines the selection criteria for staff recruitment that is required for success in the project and who takes responsibility for meeting the expectations of both community and the funder.

For Townsville, this part of the project worked extremely well. The Indigenous Advisor Programs Manager in TMML was given responsibility, able to commence community consultations from the beginning and ultimately was given the power of decision-making for the Coordinator position and able to manage the team in a highly supportive mentoring style.



3. Leadership and implementation of programs by Aboriginal and Torres Strait Islander people is essential for many reasons.

This case study demonstrated that because of the high calibre of Aboriginal and Torres Strait Islander staff leading the program, the most culturally informed approaches were taken, for example: 1) connection to community occurred appropriately, 2) both informal and formal networks were rapidly brought in as strengthening resources 3) understanding of the community and cultural challenges faced by participants was already in place and 4) the team employed non-judgmental and empowering empathetic (rather than sympathetic and rescuing) approaches.

As explained, the 'right way', i.e. cultural ways, of doing things with women that enables them to be empowered through their participation came naturally to the RHCCC team. Their Aboriginal managers recognised, protected and nurtured the people and spaces that allowed this to happen.

4. The skills, experience and personal qualities mix of the team matters.

Each member of the RHCCC team and their managers brought different skills and capacities and harmonized these in their work towards a common shared goal of better outcomes for the women. These included managerial, organisational and funds seeking skills, expertise in prison settings, health, social services and youth work. Cultural competency, Aboriginal ways of working and high level people skills were embedded within these demonstrated skill sets throughout the activities of TMML-RHCCC. This breadth of expertise facilitated effective working relationships across the multiple sectors involved and in the one-on-one support and group activities of the women.

5. Community engagement from the beginning matters.

Prior to moving ahead on the RHCCC funding request from Department of Health, the TMML manager proceeded directly to discuss the feasibility and receive insights offered by a highly respected Bindal Elder/ Community Leader who had already been working in the setting. This respectful working relationship continued throughout the whole project, manifested through continuous cultural mentorship, wise guidance and advice, respect, alignment of goals with community vision and direct integration of the Bindal Leadership Program as an entryway into case management support and the Yarning Circles. Hence this first community engagement step leveraged major benefits to TMML-RHCCC throughout the whole project.



6. Formal and informal networks and cultural brokerage skills are crucial.

The Aboriginal managers at TMML recognised from the very beginning that the extremely tight time frame and complexities of the RHCCC tasks led to the selection of a Coordinator who already had extensive networks with both the Aboriginal and Torres Strait Islander community and formal services – as well as strong cultural brokerage skills to connect, engage and build on these networks even further. The rapid and extensive achievements of the young RHCCC program repeatedly demonstrated the valuable role this played in all activities. Multiple examples were provided of how telephone calls to friends, family and services in other towns turned potential crises for women post-release into positive experiences and affirmations of caring from their community.

Five key learnings about creating and maintaining a successful model of care

1. Creating safe spaces for women to share their emotional burden is essential.

This is evidenced by the success of the one-on-one case management sessions.

2. Group programs that enable healing and leadership skills development are essential – seeking answers within.

The Bindal Leadership Program played a crucial role in helping women recognise and overcome the ways in which their trauma and painful past held them back and realize their untapped potential.

3. One-on-one support and tailored assistance amplifies these gains.

Moving from the Bindal Leadership Program into a one-on-one space for case management and ongoing post-release planning allowed a channeling of the gains made into concrete actions.

4. Experience in shifting the power balance with service providers and enabling voice in these negotiations further facilitates positive choice and getting more out of service provision.

The Yarning Circles are an expertly designed and delivered initiative that allowed women to assume an empowered position in finding out what services could offer them once they were released. Their own post-release plans assisted them in making the connections they wanted across the service spectrum, helping them be confident and pro-active in determining their care.



5. Acknowledgement and celebrations of achievement further cement these gains.

The graduations, healing retreat and DVD are the major manifestations of an ongoing respectful relationship between RHCCC and the women and are likely to be remembered and cherished by the women to help them recognise their strengths and accomplishments.

Conclusion

The evaluators commend the TMML-RHCCC team and supporting agencies for developing and achieving a high degree of implementation of an outstanding and highly complex program that very likely provided many women effective support in their journeys home from custodial care. We conclude that the team and its model of care are ideally suited for the challenges faced and strongly recommend that funding be made available for re-starting the TMML-RHCC program, and that a formal impact and outcome evaluation, with a cost-benefit analysis incorporated, based on the proposed framework and measures, commence immediately to measure the effectiveness and economic value of this excellent program.

Recommendations for using these learnings in policy and practice

1. Ensure that before any program gets underway, there is clarity and commitment at the highest levels across all essential sectors and an expectation that each will be accountable and work collaboratively with the women to ensure that timely, appropriate and effective support is provided.
2. Understand that experienced, skilled and empowered Aboriginal people working on the ground will know what to do and how to do it and act accordingly
3. Value formal and informal networks that Aboriginal and Torres Strait Islander managers and health workers bring, their previous successes and their knowledge of sustainability in decision making
4. Adopt a can do, not a can't do attitude, address entrenched can't do attitudes at all levels in the system by formalizing clear roles, responsibilities and expectations with performance monitoring



5. Establish a high level alliance across departments to address these challenges, start multisector projects at a high level, getting buy in and shared goals and accountabilities across all stakeholders
6. Establish and maintain avenues for shared accountability at all levels and ensure that essential information, e.g. providing dates of discharge and court hearings, are known to supporting stakeholders
7. Take responsibility for properly resourcing programs that work with a continuity of funding, following through with (pilot) investments and ensuring no harm is done through on/off funding.



Pictured left to right: Viaella Pryor, Joanne Bourne, Bianca Brackenridge and Aunty Jenny Pryor

Partnership with Bindal Sharks United brings leadership program to Townsville Women's Correctional Centre

The most heartbreaking thing for us would be, you make all this headway, within the system, within the community working with the ladies and across region, and if doesn't get funded, what happens then? The ladies go back to the local support with all the gaps. So we're hoping that all this work has been an investment in what can be a sustainable future for these women, having better health and wellbeing.



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Appendices

Interview and Focus Group Participants

- Tonya Grant, Indigenous Advisor Programs Manager and Carl Grant, General Manager Indigenous Programs at TMML
- Joanne Bourne, RHCCC Program Coordinator and Bianca Brackenridge, RHCCC Project Officer
- Auntie Jenny Pryor, Traditional Owner Bindal Elder, CEO of Bindal Sharks United Sports and Recreation Aboriginal Corporation and developer and deliverer of the Bindal Leadership Program
- Four representatives of Management of the Townsville Women's Correctional Centre team
- Peta Anderson, Case Manager, Offender Reintegration Support Service (ORRS), Townsville

Interview guide

Introduction

- Muru Marri, who we are and what we do
- Your organisation/service and your role
 - What does your organisation/service do?
 - How does your organisation/service contribute with women returning home from prison? What is your role?
 -

Returning Home project

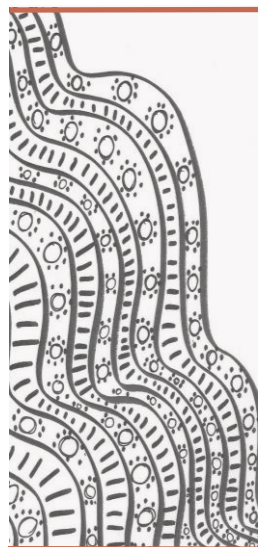
- What outcomes would you like to see for women returning home from prison? Can you describe your ideal scenario?
- What is your understanding about the Returning Home project?
- What is your role with Returning Home?
- What do you hope for Returning Home to achieve in your area?
- What have been your experiences with Returning Home so far?
- What have been the main achievements and challenges?
- What are your expectations for the next few months?

Other matters

- Other items of interest
- Next steps, thanks and closing



Appendix A3. Case study report for Western Sydney site



Returning Home, Back to Community from Custodial Care

First Year Pilot Project

Evaluation Report for Western Sydney site

August 2014

This case study was conducted as a partnership between the project developers and deliverers:

Aboriginal Medical Service Western Sydney

Mt Druitt Village NSW 2770

and project evaluators:

Muru Marri, School of Public Health and Community Medicine,
UNSW Australia

UNSW Sydney NSW 2052

,With funding provided by:

Department of Health

Commonwealth Government

Canberra ACT 2600





Acknowledgements

In the spirit of respect, we acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia.

This work was done on the land of the Aboriginal peoples who are and always will remain the Traditional Owners of the Land where the metropolis and cities of broader Sydney now stands.

This case study, which is part of a national pilot project funded by the Department of Health, aimed to produce a mutually useful product that reflects the knowledge and experience and community connections of the program developers, deliverers and evaluators. The partners—Muru Marri and Aboriginal Medical Service Western Sydney—share a common goal; that the story that has emerged can be of local benefit and also inform and inspire other programs for Aboriginal and Torres Strait Islander women going back to community after a custodial sentence.

AMSWS staff directly quoted in this report are Dea Delaney-Thiele, Director, Population Health Research Unit, AMSWS; Leanne Schuster, Manager, Social and Emotional Wellbeing Team, AMSWS; and Sheilah Hure, Public Health Officer and Team Leader, Health Promotion Team, AMSWS. Quotes appear in italics.

Acronyms

ABS	Australian Bureau of Statistics
AHW	Aboriginal Health Worker
AMSWS	Aboriginal Medical Service Western Sydney
CSNSW	Corrective Services NSW
DoH	Department of Health
JH&FMHN	Justice Health & Forensic Mental Health Network
NACCHO	National Aboriginal Community Controlled Organisation
NSW	New South Wales
SPRINT	Services and Primary health care needs for Recently Released Inmates in Need of Treatment and health management
WSML	Western Sydney Medicare Local



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Maru Marri

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Prologue: Introduction to Returning Home, *Back to the Community from Custodial Care*

Returning Home, Back to the Community from Custodial Care was a national project funded by the Commonwealth Department of Health. The project aimed to develop effective models of care that will enhance the health and wellbeing of Aboriginal and Torres Strait Islander women returning to the community from prison. The first year pilot project was implemented at three sites around the country: Geraldton in Western Australia, Townsville in Queensland and Western Sydney in New South Wales.

Muru Marri, an academic unit of the School of Public Health and Community Medicine at UNSW Australia (UNSW), was commissioned to undertake a formative evaluation of the pilot project, using a case study approach to tell the story of the progression of plans at each location—from the initial ideas to the model of care. This report documents the people and processes involved, the challenges encountered, the emerging model of care and the lessons learned in Western Sydney and at the Aboriginal Medical Service Western Sydney (AMSWS).

Returning Home, Back to the Community from Custodial Care emerged from the *Services and Primary health care needs for Recently released Inmates in Need of Treatment and health management* (SPRINT) study, which sought to provide a culturally-specific understanding of how primary health care services can improve health care and social support for Aboriginal people in contact with the criminal justice system and transitioning from prison back into the community. The AMSWS were a partner involved in this SPRINT study. The necessity for a wholistic and integrated case management approach was highlighted. The project provided the opportunity for primary health care services operating in diverse regions of Australia to create and implement a culturally and locally-appropriate care coordination model that incorporated such an approach.



Executive summary

Sydney has the highest population of Aboriginal and Torres Strait Islander residents in Australia, with many residing in the Western Sydney area. This area also has three correctional facilities for women, namely Silverwater Women's Correctional Centre, Dillwynia Correction Centre and Emu Plains Correctional Centre. The Aboriginal Medical Service Western Sydney (AMSWS) has a long history of working within these correctional centres, as well as experience undertaking the *Services and Primary health care needs for Recently released Inmates in Need of Treatment and health management* (SPRINT) study.

The *Returning Home, Back to Community from Custodial Care* pilot project was funded by the Commonwealth Department of Health, through the Regionally Tailored Primary Health Care Initiatives through Medical Locals Fund. While Western Sydney Medicare Local was initially contracted to undertake the pilot, network mapping and advocacy by AMSWS resulted in the Medicare Local sub-contracting AMSWS to undertake the project.

The AMSWS has a long history successfully delivering comprehensive primary health care to many thousands of Aboriginal and Torres Strait Islander people in Western Sydney, and engaging and supporting those in the criminal justice system and their families. The SPRINT study found that Corrective Services NSW (CSNSW) throughcare policy is still to be fully realised in practice; and that primary health care services could do more to support Aboriginal people on their release from custody. The *Returning Home, Back to Community from Custodial Care* pilot was designed to build an improved understanding of the most appropriate model of care that Aboriginal and Torres Strait Islander women can expect from community-based service providers who are focused on improving their health outcomes, especially those related to mental health.

AMSWS referred to their work as 'Back to Community'. The Back to Community pilot was embedded in the Social and Emotional Wellbeing Team at the AMSWS, which works from an Aboriginal-led, wholistic, ecological model, its values reflecting those in the 1989 *National Aboriginal Health Strategy*, as well as taking a human rights, collaborative and leadership role in improving the health and wellbeing of Aboriginal and Torres Strait Islander people.

This formative evaluation case study sought to tell the story of the progression of plans at the Western Sydney location—from the initial ideas to the model of care. Data collection methods used included group interviews with staff from the AMSWS and CSNSW and a document review; the ecological model forms the basis of its analysis.



The Western Sydney pilot project adopted a wholistic approach that emphasised “*empowerment, assistance, access*” (AMSWWS, 2013).

At the individual level, working with Aboriginal women pre- and post-prison release, key elements of the emergent model included development and use of a needs assessment tool, care coordination for 12 women and connection to a range of other services for support.

At the organisational and sectoral levels, AMSWS identified and developed opportunities for care pathways, collaborations and partnerships, as well as embedding principles and processes for working with Aboriginal women exiting correctional centres, and their families in the AMS. They planned a number of community-based interventions with a focus on family and community support, such as healing camps, and engaged with Elders and seniors to mentor the women re-entering the community.

At the system or structural level, AMSWS actively sought to build relationships with women prior to their exit from prison. Frustratingly, however, AMSWS's applications to CSNSW and Justice Health & Forensic Mental Health Network (JH&FMHN) to access the correctional centres as a Professional Visitor were never processed. Nor, therefore, approved. Although AMSWS Back to Community staff initially entered the prisons as general community visitors, this was subsequently denied by CSNSW, whilst the Professional Visitor applications remained in process.

The lack of approval to enter the three correctional centres put an end to AMSWS's capacity to implement one of the key features of their model of care—connecting with Aboriginal women pre-release, to develop a relationship, engender trust and to identify specific needs and options. The AMSWS were forced to rely on CSNSW, JH&FMHN and others' recommendations to Aboriginal women that they access the AMSWS's post-release program, or by the AMSWS itself chasing up referrals upon the women's release.

As a result of these efforts some connections were made, but were nevertheless ad hoc rather than systematic, perpetuating the multiple challenges Aboriginal women already face upon release from custody and pointing to the urgent need to address the gaps in communication and understanding between and within State Departments of Health and Corrections and the Commonwealth.

Other key barriers for supporting Aboriginal women are outlined in this report. They are not issues about supporting Aboriginal women, nor about the model of care; but are generally about system barriers such as the need to improve intra-



and inter-government communication and partnerships. These include poor data availability, information sharing and accountability; and lack of leadership to overcome disadvantage, address discrimination and racism; and the need to rectify ineffective expenditure by governments, particularly in the areas of Aboriginal and Torres Strait Islander health and criminal justice where there is ever-increasing over-representation of Aboriginal and Torres Strait Islander people.

The 'lessons learned' and recommendations included in this report reflect the wholistic model of health enacted by AMSWS. This supports Aboriginal women exiting correctional centres across physical, social, emotional, spiritual, mental and cultural domains of life, and across individual, family and community, organisational and structural levels.

Based on the literature and findings from this formative evaluation, overarching recommendations are that:

- Gender sensitive, wholistic model of care, such as that developed by the AMSWS for Aboriginal women exiting custody, and her family and supports, are made available in adequately funded and resourced community-based programs, and are implemented and evaluated as a matter of priority.
- Aboriginal community-controlled health services and their partners, throughout Australia, develop and have funded models of care to support Aboriginal women from pre- to post-release, with these programs networked through a peak body such as NACCHO.
- The AMSWS continues to work, in collaboration with others, on enhancing relationships with CSNSW, and advocates that appropriate structures be put in place to support effective throughcare in line with Departmental policy.
- CSNSW ensures that appropriate structures are in place to support effective throughcare in line with policy and responsibilities, with transparent performance indicators and accountability.
- All agencies and organisations with responsibility for affecting the lives of Aboriginal women in prison and their families develop clear agreements and accountability mechanisms that ensure intra- and intersectoral connection and pathways both locally and across the state, to meet the wholistic needs and rights of Aboriginal and Torres Strait Islander people.
- Ongoing development of State and Commonwealth expenditure on Aboriginal and Torres Strait Islander health and criminal justice programs occurs, to enable leadership and priority setting by Aboriginal and Torres Strait Islander people in local communities, and including provision for continual funding of pilot projects that show promise, in



order to retain staff, maintain relationships with service users, and sustain organisational capacity building.

More detailed discussion on these and other recommendations occurs toward the end of this report.

Background

Aboriginal and Torres Strait Islander women returning home after serving a custodial sentence face enormous challenges. Many are burdened by multiple long-standing health and wellbeing issues, which, like their incarceration, stem from the devastating loss of land, culture and family caused by colonisation and the social, economic and educational disadvantage that continues today (Poroch, 2007; Krieg, 2006). Health problems frequently experienced include substance misuse, mental health issues, blood-borne viruses (hepatitis A and B) and chronic diseases such as diabetes and cardiovascular disease (Indig, McEntyre, Page and Ross, 2010). These make dealing with all of the requirements of returning to the community after incarceration even harder, to meet their basic social, emotional and physical needs and re-establish roles and relationships with their families and communities (SPRINT Project Team, 2013).

Effectively addressing these issues requires access to coordinated and culturally-appropriate programs targeted to Aboriginal and Torres Strait Islander women that are based on a wholistic throughcare model and incorporate reception planning, case management, transitional programs and mental health support (Baldry and McCausland, 2009). Linking the women with safe and secure housing as well as primary health care and community services is fundamental to ensuring positive outcomes. Provision of support that enables further engagement with a comprehensive range of services and employment opportunities offers women their best chance for not returning to custodial care (SPRINT Project Team, 2013; Bartels and Gaffney, 2011).

The Returning Home, Back to Community from Custodial Care pilot project was designed to build an improved understanding of the most appropriate model of care that Aboriginal and Torres Strait Islander women can expect from community-based service providers who are focused on improving their health outcomes, especially those related to mental health. The evaluation team was tasked with identifying the best approaches in primary health care service delivery that enable improved transition arrangements for Aboriginal and Torres Strait Islander women, and learnings that can lead to developing models of care to support the wider population for whom release from prison is imminent, to ultimately reduce risks for reincarceration.



Establishing the Western Sydney Returning Home pilot project

Project setting

Sydney has the highest number of Aboriginal and Torres Strait Islander residents in Australia, with a large proportion residing in the Western Sydney (Australian Bureau of Statistics, 2013).

In Western Sydney, Corrective Services NSW (CSNSW) operates three correctional centres for women: Silverwater Women's Correctional Centre, Dillwynia Correctional Centre and Emu Plains Correctional Centre. There are five other female-only units outside Western Sydney, in Broken Hill, Wellington and Mid North Coast Correctional Centres.

Silverwater Women's Correctional Centre, one of three facilities that comprise the Silverwater Correctional Complex, is a maximum security facility for women and the main reception centre for female offenders in NSW.

Dillwynia Correctional Centre is a medium security facility for women located within the John Morony Correctional Complex near Windsor. Emu Plains Correctional Centre is a minimum security institution for females near Penrith, at which children can stay with incarcerated mothers. CSNSW has a handbook of information for women in custody, a Principle Advisor for women offenders, an Aboriginal Strategy & Policy Unit and a Regional Aboriginal Project Officer who works closely with Aboriginal women in custody and advocates for their needs; this officer became a key contact for the AMSWS Back to Community pilot.

CSNSW also has a 'Strategy for supporting Aboriginal Offenders to desist from re-offending' (CSNSW, 2014) and has as one of its priorities: "*Promoting successful re-settlement through partnerships with other agencies and community groups*" (CSNSW, n.d), by funding a small amount of non-government organisations through a tendering process as part of its throughcare strategy, including for transitional support.

The Justice Health & Forensic Mental Health Network (JH&FMHN) is a statutory health authority and specialist area funded by NSW Ministry of Health, responsible for the provision of clinical and population health services including access to community-based health care. In addition to custodial case officers, staff include welfare officers, psychologists and drug and alcohol workers. Within the prison, a case plan is to be developed by CSNSW Offender Services & Programs staff based on the initial assessment, outlining the activities and interventions that the women will receive during their sentence. There have been many reported barriers to completing these successfully, and to ensuring they are transformed into appropriate actions in the transition from prison to



community (for example Maruna and Immerigeon, 2004; Goulding, 2004; Petersilia, 2003; Ross, 2003).

There were a small number of other strategies relating to women in prison occurring at the time *Returning Home, Back to Community from Custodial Care* pilot was implemented. Simultaneously with its development, NSW Government was drafting an *Aboriginal Women Leaving Custody Strategy* to ensure a coordinated response across the state, with the aim of reducing rates of homelessness and reoffending and improving quality of life measures. Within Silverwater Women's Correctional Centre, Legal Aid NSW, funded through the National Partnership Agreement on Homelessness, was advocating on behalf of Aboriginal women "to secure sustainable housing and resolve legal issues that are an impediment to gaining housing such as issues with Housing NSW, Centrelink and unresolved debt." (Legal Aid NSW, 2013).

Western Sydney Returning Home pilot development

Returning Home funding to Western Sydney Medicare Local

Returning Home began in Western Sydney by the Commonwealth Department of Health (DoH) inviting the Western Sydney Medicare Local (WSML) to conduct the pilot project. The Western Sydney Medical Local, established in 2011, with its origins in WentWest Division of General Practice established in 2002. Its aim is to *connect health services to meet local needs*, with its key operational tasks being general practitioner and health care worker training, and assisting health and allied health providers to develop their clinics and practices. They have a Aboriginal and Torres Strait Islander health unit with outreach workers connecting to clinical and community services (WentWest Limited, 2013; Roxon, 2011).

The service agreement between the DOH and WSML described the *Returning Home, Back to Community from Custodial Care* project aim as (Department of Health and Ageing, 2013, p. 1):

"To provide support to Aboriginal and Torres Strait Islander women returning back into the community from their recent custodial sentence. This includes providing culturally appropriate support and guidance to enable engagement and connection with relevant service providers in the area of primary health care (including AMS providers), mental health services, family support officers, women health and wellbeing providers. Importantly there is a need to link health care service outcomes during custodial care to ongoing primary health care in the community. Finally the



clients should be enrolled in Personally Controlled Electronic Health Record (PCEHR) program.”

Following some community engagement and service mapping by WSML, the Aboriginal Medical Service Western Sydney (AMSWS) was identified as the most appropriate organisation to develop and deliver the pilot in Western Sydney. AMSWS also directly advocated for this, highlighting their leadership in this area, with recent experience researching and supporting Aboriginal people transitioning from correctional centres, and decades of experience delivering of comprehensive primary health care to Aboriginal people in Western Sydney. WSML subsequently subcontracted the AMSWS to undertake Returning Home, with AMSWS reporting directly to WSML with guidelines and the clear agreement that the funding was time-limited.

From the Western Sydney Medical Local to the Aboriginal Medical Service Western Sydney

The AMSWS is one of the largest Aboriginal Medical Services in Australia. It was established in 1987 to provide wholistic comprehensive primary health care in the Aboriginal community of Western Sydney. It is located in Mt Druitt within walking distance of public transport and close proximity to schools, shops and a range of health and support services. The AMSWS is in the Deerubbin Local Aboriginal Land Council Area, which covers a land area of over 3600 square kilometres (Figure 1). The 2011 Census shows the region had an Aboriginal and Torres Strait Islander population of 21,333 people (ABS, 2013).



Figure 1: Map of Deerubbin Local Aboriginal Land Council area, across which AMSWS primarily works (taken from the AMSWS Strategic Plan)



Across this geographical area, the AMSWS undertakes many thousands of interactions with Aboriginal and Torres Strait Islander people per year. Its agenda is clearly defined in its Strategic Plan, and reiterated in annual reporting, and highlights their priorities of effective services, leadership and capacity building as being underpinned by the values of the *National Aboriginal Health Strategy* of 1989 including wholistic care, Aboriginal perspectives of history and health, self-determination, and strong and resilient relationships (AMSWS, 2011). Its services are diverse, including accredited comprehensive medical services, oral health services, a Chronic Care Program, Social and Emotional Wellbeing Program, Child and Family Health Team, Healthy Lifestyles and Tackling Tobacco Program, domestic violence and health promotion programs and Elders/Seniors Program. Several specialist services occur through partnership supported by Western Sydney Local Health District and a range of other partnerships exist with diverse services. These programs access a range of State and Commonwealth government funding (AMSWS, 2012).

AMSWS staff are supported in developing skills in research, Continuous Quality Improvement and leadership in public health. Several are involved in governance of other community organisations, and represent AMSWS on advisory and reference committees at local, state, national and international levels.

Some staff have direct experience working in correctional environments. AMSWS has a long history of engaging with Aboriginal people in the criminal justice system and in prisons, either through their clinic, community services and outreach, or through 'in-reach' to prisons. In the 1990s, for example, AMSWS



received State funds for Aboriginal Health Workers and general practitioners affiliated with the AMSWS to access Aboriginal people in prison right across NSW. The AMSWS have funded this work in local prisons. They have developed and maintained partnerships and shared work histories with many services and general practitioners currently working with people in local prisons. Beyond service delivery, the AMSWS was involved with the SPRINT Study, to “*get the evidence base that we need to try to get our much needed resources*” (Dea Delaney-Thiele, Population Health Research Unit, AMSWS) and have been involved in policy development and advocacy for reform across Commonwealth and State health and justice portfolios.

The AMSWS advocated to WSML to undertake the pilot project in order, to build on recent insights from the SPRINT study and their previous experience supporting Aboriginal and Torres Strait Islander people in the criminal justice system, and leverage off its current services and connections. The Returning Home project plan submitted by AMSWS to WSML focussed on providing care coordination to clients and promoting collaborative arrangements with a wide range of service providers to meet cultural, physical, mental, social and emotional needs of Aboriginal women exiting correctional facilities in Western Sydney. This pilot is known locally as ‘Back to Community’.

There were frustrations were felt by those establishing Back to Community at AMSWS, in part from being secondarily considered to undertake the pilot and further exacerbated by unclear processes for communication with DOH and WSML. At the time, a Partnership Agreement was newly in place between WSML and AMSWS, defining a collaborative, equal relationship to improve health outcomes for Aboriginal and Torres Strait Islander people in Western Sydney (AMSWS, 2012).

This introduces two key contextual aspects of the AMSWS pilot – navigating different levels of government and services to establish pathways for care for Aboriginal and Torres Strait Islander women exiting correctional facilities, and the changing political and service delivery landscape in which to do this. These and other system-level issues are discussed further below, after the evaluation methods are explained.

Formative evaluation: methods used

A formative evaluation is one method for judging the worth of a program while the program activities are forming (Owen and Rogers, 1999). The main data collection methods comprised group interviews with AMSWS and CSNSW service managers and providers, and a document review.

A background interview was conducted with CSNSW in early-March 2014. Two interviews were conducted with AMSWS in early-May and mid-July. The Back to Community worker was not available for interview due to her resignation and hence early termination of her contract. Appendix 1 contains a list of people consulted and Appendix 2 contains the semi-structured interview guide.

Documents reviewed included the WSML proposal, needs assessment and project plan provided by AMSWS; the AMSWS interim report on Back to Community; the *AMSWS Strategic Plan 2011–2016, Annual Report 2011–2012* and *Our History*; and materials developed for the project, including promotional brochure and assessment tools .

Verbal reports on progress and challenges were provided at the national project meeting in September 2013 and again at the national teleconference in November. Two national project newsletters, produced in January and May 2014, provided a means of sharing information about developments across all project sites.

Figure 2: Photo taken at second AMSWS group interview, from left to right: Leanne Schuster, Dea Delaney-Thiele and Sheilah Hure (AMSWS), Lisa Jackson Pulver, Ilse Blignault, Marcia Grand Ortega, Melissa Haswell and Megan Williams (Muru Marri)





AMSWS Back to Community pilot project implementation

Aims and activities

AMSWS developed seven aims for their Back to Community pilot:

1. Improve community-based support when Aboriginal women are leaving custody.
2. Consider culturally appropriate healing programs that address their physical, social, emotional and mental health needs.
3. Provide access to primary health care services, targeting problem areas that include reviewing their medications, and the provision of appropriately focused counselling.
4. Work collaboratively with other key partners to develop pathways between the community and custody to ensure effective transfer of information services and program support within a throughcare framework.
5. Develop case management plans to ensure a streamlined process between all appropriate social service providers such as Department of Housing NSW, Centrelink and TAFE etc.
6. Ensure the enrolment of participating women in the Personally Controlled Electronic Health Record (PCEHR) program.
7. Review legislative and policy provisions to better assist Aboriginal offenders' transitioning back into the community.

These aims reflect the many individual, community and system-level issues to address in improving the transition of Aboriginal women from prison to sustained and connected living in the community.

Organisationally, Back to Community was incorporated within the AMSWS Social and Emotional Wellbeing Team. A well-regarded, experienced and appropriately qualified Aboriginal woman, Lizzie May, was recruited into the Back to Community Care Coordinator position. She had with extensive community connections both locally and across NSW, was herself a part of the local Aboriginal community, and considered a mature leader. As described by AMSWS staff interviewed for this formative evaluation, she had *"a passion for women in corrections and families"* (Leanne Schuster, Team Leader, Social and Emotional Wellbeing Team, AMSWS), with considerable previous experience engaging with the many complex issues women experienced. The full-time Back to Community Care Coordinator received on ongoing support from the team manager and colleagues throughout AMSWS.



As Table 1 shows, AMSWS quickly made progress in developing pilot materials and processes for their work. By the end of December 2013, the Back to Community Care Coordinator had received 12 referrals of women soon to be released from custody through networking and word-of-mouth.

Progress was stalled by approval for the Back to Community worker and related AMSWS staff not being processed for entry to correctional centres as Professional Visitors, by either CSNSW or JH&FMHN. This meant the Back to Community team could no longer visit the correctional centres to meet with women prior to their release, nor could they liaise effectively with prison staff to identify women for whom prison release was imminent.

In April 2014, the Back to Community Care Coordinator ceased her role with Back to Community, having resigned to take up permanent employment elsewhere. Given the short time remaining for the pilot project, it was not feasible to recruit a replacement nor apply to have them approved by CSNSW as a Professional Visitor.

The summary of activities below by AMSWS Back to Community pilot shows clearly their working across the various 'levels' in Aboriginal health, reflecting their organizational commitment to wholistic health care, the Aboriginal definition of health (NAHSWP, 1989) and an eco-social model of health (Krieger, 2011). This case study identified key aspects of the AMSWS's efforts across each of these levels, and the next sections of this report are structured according to these levels – identifying: 1) key elements of the model, 2) issues and barriers, and 3) lessons learned including recommendations.

Table 1: Overview of Back to Community project activities

Month	Activities	
June 2013	<ul style="list-style-type: none"> WSML invited by DOH to conduct pilot project AMSWS subcontracted by WSML to implement project 	
Sep 2013	<ul style="list-style-type: none"> Needs assessment and project plan submitted by AMSWS to WSML/DOH National meeting with all project sites on 13 September, Canberra 	<p>Ongoing activities during this period:</p> <ul style="list-style-type: none"> Pamphlet and magnet developed and distributed Planning pathways for women accessing AMSWS, including developing referral form Development of MOUs including with JH&FMHN and CSNSW Introduction of the pilot to local services Extensive needs assessment tool developed Case plan committee/team established Roundtable meeting with key stakeholders Prison visits Conducting needs assessments Providing support to Aboriginal women pre- and post-prison release High demand to secure long-term housing for women, with minimal success Developing relationships and partnerships with several varying communities and services outside Western Sydney, to which Aboriginal women will return after release from Western Sydney centres Connection to AMSWS's Golden Oldies program, for mentoring for women from Elders Planning for 3 healing camps E-Resource folder developed Commenced literature review and data collection report of laws and policies.
Oct 2013	<ul style="list-style-type: none"> RH Worker employed 	
Nov 2013	<ul style="list-style-type: none"> National teleconference with all project sites, 1 November 	
Dec 2013	<ul style="list-style-type: none"> Interim report submitted to DOH by AMSWS 12 referrals received 	
March 2014	<ul style="list-style-type: none"> Evaluation interview with CSNSW RH Worker resigns April 2014 	
May 2014	<ul style="list-style-type: none"> First evaluation interview with AMSWS 	
July 2014	<ul style="list-style-type: none"> Second evaluation interview with AMSWS 	
August 2014	<ul style="list-style-type: none"> Evaluation report submitted by Muru Marri 	



Key elements of the AMSWS Back to Community model

At the individual level

Experience and readiness to work holistically

The AMSWS drew on decades of experience working holistically, through access to their integrated comprehensive primary health care. They also worked with individuals and families, and across generations, passing messages from those in custody to parents and Elders, positioning the *Golden Oldies* to become mentors for the women, and engaging with legal and family services about child access issues:

The AMS model is really good at helping them with any of those social services that they need, as well as the health and the medical sort of side of things (Leanne).

Care coordination

The central feature of the AMSWS Back to Community model was a dedicated worker undertaking care coordination. As described by AMSWS, *It's a hands-on model. Our networks are extensive. We will find the right service for them and connect them up (Leanne)*. Further, *They're the connector. Provided by the AMS. With the in-reach sort of services (Dea)*.

Developing relationships

The AMSWS already had many established working relationships across sectors and services that were relevant to supporting Aboriginal women exiting correctional centres. The AMSWS and Back to Community staff were also known by some of the women and their families. That Back to Community was in an Aboriginal staff and service context meant recognition of Aboriginal identity, cultural care and values base, particularly clearly espoused by the AMSWS context. All of these features were thought to help build rapport and trust in relationships with Aboriginal women:

That was something to come out of those visits was that people weren't willing to engage with the clinic or see them in the clinic, but they were quite happy to talk to the social workers or Lizzie (Leanne).



Identifying individual women's needs

AMSWS Back to Community designed a pre- and post-prison release assessment tool to identify the major issues for each client so that support could be tailored accordingly, as well as protocols for case conferencing and care planning.

The assessment tool, which incorporated a number of widely-used scales, included questions to explore the following issues in depth: accommodation, living arrangements and safety; functional abilities; alcohol, smoking and substance use; care relationships and family and social support networks, including pregnancy support; general health and health literacy, including chronic conditions; and need for assistance with activities of daily living. While lengthy, it was not intended that it be completed at the one time:

In regards to the screening tool, we actually cut it in half. Lizzie and I discussed – she found it was – what was important was to build the rapport and the trust with the person. So we didn't want to go through reams and reams of paperwork. So we just did a basic needs assessment. Then, on post-release, we would complete the screening (Leanne).

AMSWS staff expect to continue to use the assessment tool, given that it was helpful, tailored and encouraged conversation with the women.

Culturally-relevant healing

AMSWS Back to Community aimed to connect Aboriginal women with culturally appropriate healing programs that address their physical, social, emotional and mental health needs. Consistent with other programs delivered by the AMSWS Social and Emotional Wellbeing Team, it highlighted the significance of Aboriginal culture in facilitating family and community involvement, building social competencies, and connecting with education and training opportunities. Individual case work, building relationships and trust, and establishment of mentoring relationships with Elders were an early focus. Three healing camps were planned for the second six months, acknowledging the importance of activities such as these in supporting individuals in their healing and connection to family and community. However, for several reasons these were not able to occur.

At the community level

Community-based interventions with focus on family and community support

The Returning Home Worker worked not only with individual Aboriginal women, but also with child and family related issues, as well as connecting with



extended family, community members and Elders. As noted earlier, one community-based strategy being put in place was connection with Elders and seniors of the community for an important source of mentorship, particularly through the *Golden Oldies* program and activities.

Networks and assistance for women returning to communities outside Western Sydney

Back to Community staff found that approximately three quarters of the Aboriginal women exiting the correctional centres in Western Sydney were from communities outside the area. They were provided with support and assistance to do so:

So what we decided was rather than dismiss their needs, we took them on board as well and Lizzy would negotiate with services in other areas, other AMSs and other housing departments. So if they went to Bree [Brewarrina], then she would negotiate with AMSs and send information. So that's what we found... whether they were Redfern women or Liverpool women, but she would still put in place whatever support (Leanne).

At the services level

Experienced Aboriginal staff and context

As stated earlier, the AMSWS recruited a well-regarded, experienced and appropriately qualified Aboriginal woman into the Back to Community Care Coordinator position. AMSWS staff, in interview, explained that when access to correctional centres was possible, *obviously to go into those kind of environments takes a certain person to be able to go into there. Further, she knew how to conduct herself when she was in there and generally more so that she knew the people that she was going there to see or knew their family or made a connection, so they were able to bond straight away (Leanne).* The Care Coordinator had *knowledge of the community and the networks and what the processes are involved, was accepted as an Aboriginal person, living in the local area for 40 years. She brought considerable previous experience engaging with the many complex issues they experienced as well as the personal linkage. So if somebody makes a connection, but there's also an organisational linkage and you've got both of those actually happening (Leanne).* This mixed role enhanced the trust and openness with Aboriginal women – the Care Coordinator was *very engaging without being too patronizing (Leanne).*

The Back to Community pilot occurred within a dynamic broader Social and Emotional Wellbeing team, with supervision and administrative support. It was embedded in the broader AMSWS, with its clear Aboriginal leadership and



values, and itself networked with other Aboriginal comprehensive primary health and medical services through the peak body, the National Aboriginal Community-Controlled Health Organisation (NACCHO).

Collaboration and partnerships

One of the key enablers was AMSWS's ability to build networks, and develop relationships with a range of local, regional and statewide service providers. The latter are important, as the majority of Aboriginal women prisoners held at the Silverwater, Dillwynia and Emu Plains Correctional Centres return to communities outside Western Sydney. In particular, the project led to enhanced relationships with the Aboriginal Support Unit within CSNSW, the JH&FMHN and Legal Aid. The Back to Community worker participated in CSNSW Network Meetings and attended other meetings related to Aboriginal prisoner support.

As noted earlier, obtaining Professional Visitor access to the correctional centers proved problematic. This issue was never satisfactorily resolved. It was therefore difficult for the Back to Community worker to meet with the women prisoners in order to establish the relationships and commence the planning process necessary to facilitate access to AMSWS and other services on their release—critical elements in an effective model care. There seemed to reflect a lack of coordination and communication between the Commonwealth Department that funded Returning Home, and the State Government services to enable access to the overwhelmingly disadvantaged target group.

Because we've got those connections, you know. So that's really important that we're at the table where all the decision makers are, across the system (Dea).

This resulted in referrals to AMSWS, despite their not having access to the prisons. Some CSNSW and other staff helped connect with women, and then with AMSWS.

We had a meeting with Corrections at Dillwynia and Emu Plains, Balmoral, and they facilitated a number of assessments to happen while we did the visits but then they clamped down and said "No, you have no clearance. You can't do it." So what we ended up happening was that we would find out through other means when a woman was to be released" (Leanne)



At the system level

Flexibility

AMSWS clearly experienced gaps in communication, collaboration and accountability between government departments and services. During Back to Community, examples such as that above, show the AMSWS to be an active participant in the changing landscape of health services in Western Sydney. They were ready to participate, could delegate where needed and followed up on opportunities to improve how services were available to Aboriginal women in prison. AMSWS staff described how they adapted to the changing landscape, being *flexible... There was all the formal stuff we had envisaged went out the window* (Leanne). For example, despite no access to the prisons, they used, developed and adapted networks and existing AMSWS mechanisms to ensure they could still receive referrals from the correctional centres to facilitate access to Back to Community support for women being released. They would also use community connections and relationships to encourage connection by the women where possible and appropriate.

Advocacy and accountability

At one point in the Back to Community pilot, when access to correctional centres could no longer occur, and the approvals to enter as Professional Visitors had been so delayed, the Back to Community Care Coordinator identified a need and process for gathering key stakeholders, to inform their plans for how to proceed. This was to both keep the Back to Community pilot developing and accountable, as well as keep CSNSW and others accountable. Other services had also expressed to AMSWS they were experiencing difficulties accessing Aboriginal people in custody, and a Roundtable meeting occurred:

...because things just weren't happening and we felt there was a lot of deliberate obstruction, and not just with us, it was also with [other] programs and that too. So we decided to sit on a round table and look at what was going on, what needed to happen (Leanne).

This meeting occurred in the Emu Plains correctional centre context. *Then from that meeting came "We need the same sort of roundtable meeting at Dillwynia and at Silverwater." It never came about* (Leanne).

Reflection on the pilot, to inform an ideal model

Following is a brief summary of features of a suggested, 'ideal' model of service for supporting Aboriginal women in prisons, who are to be released to the



community. Details were recommended by AMSWS staff during the evaluation interviews. It provides a brief, additional insight into rich ‘forward thinking’ information provided by AMSWS, reflecting on their experience piloting Back to Community; opportunities for which usefully arise from evaluation processes and are crucial given the history of under-evaluation of Aboriginal and Torres Strait Islander programs (LaFrance and Nichols, 2010; Davis and Brands, 2008).

Location: Back to Community staff located half-time in the correctional centre/s and half time at the AMS; appropriate access to the correctional centres

Roles: Care Coordination for Aboriginal women exiting correctional centres – flexible, practical linkage support based on rapport and trust between the woman and support worker; the same person conducting care coordination inside the prison pre-release, being available at the time of release from prison, and providing support in the community post-release; to meet social, emotional, cultural, mental, physical and spiritual needs; identification of needs through a structured process; connection to integrated wholistic care offered at the AMS; collaboration and development of trusting relationships with other services to also meet needs of women and their families.

Approach: Gender specific; empowering; addressing determinants of health including housing, legal issues, training and employment; collaborative, working closely with the women and a range of other services; recognition of the history of trauma, exclusion and racism Aboriginal and Torres Strait Islander peoples have experienced; underpinned by AMSWS values and the 1989 *National Aboriginal Health Strategy*.

Timing: Develop relationships with the women in custody, as well as key staff and community service providers; undertake pre- and post-release needs assessments; continue working post-prison and connect to longer-term support through the AMS.

Accountability: Key Performance Indicators set for the funding body as well as funding recipients; funding and accountability for its management and reporting located in the AMS, with responsibility to the Aboriginal community to meet outcomes; MOUs and agreements made between service providers and stakeholders about roles and responsibilities; care plans negotiated and reviewed with the women and her supports as well as involved services; development of software to be used in integrated care from pre- to post-prison release; connection and reportage to other AMSs also conducting transition care coordinated through a state and national structure, supported by a peak body such as NACCHO.



Proposed framework for a summative evaluation

A summative evaluation is a method of judging the worth of a program after the program activities are fully implemented. The focus in a summative evaluation is on outcomes (Owen & Rogers, 1999). If Back to Community were to continue and is successful, it is expected that the Aboriginal women involved will show reduced recidivism and improved health and wellbeing outcomes.

At the service level, in addition to the total number of women engaged, summative evaluation measures should reflect the types of assistance provided. Examples include:

- housing—how many clients have suitable accommodation
- health—how many clients have a regular GP, how many are in counselling or have a mental health care plan
- social—how many clients are employed or enrolled in a course, how many have been in trouble with the law or re-incarcerated
- family—how many clients have regular access to their children
- community and culture—how many clients participate in community events.

At the individual level, client satisfaction measures are important. In addition, relevant sections of the Returning Home assessment tool could be re-administered to provide a pre- and post-measure. Employing a culturally-appropriate and validated tool such as the Growth and Empowerment Measure (GEM; Haswell et al., 2010) may also be useful. Client stories and case studies collected on a periodic basis will provide important qualitative information.

Lessons learned and recommendations

This section of the formative evaluation report reflects on the features of the model of care developed by AMSWS, their recommendations for future support work of Aboriginal women exiting custody, and their experiences undertaking the pilot. It is clear there were many system-level challenges and obstacles to connecting with Aboriginal women in prison; interview material captured further detail about these challenges and while not fully reported here nonetheless informed this report.

Material presented below is interpreted in such a way as to contribute to the design and delivery of wholistic support services with Aboriginal women pre- and post-prison release in the future. This section is again structured according to levels in a wholistic, eco-social health care model, to reinforce the important



message the AMSWS provided to the evaluation team, which is that support for Aboriginal women must occur well beyond the individual and must also reach her family and community supports, with organisations and criminal justice and health systems cognisant of and arranged in such a way that they are intra- and intersectorally connected to meet the wholistic needs and rights of Aboriginal and Torres Strait Islander people.

At the individual level

Programs for Aboriginal women must be gender-sensitive. A recent review of good practice in women's corrections (Bartels and Gaffney, 2011) found that corrections systems tend to be organised around the needs of male prisoners, with special provisions for women being 'added on' in an ad hoc fashion – only if there was the will locally. Further, Aboriginal women in prison face additional challenges of racism and discrimination. The Back to Community team found that programs directed to meeting the health and other needs of Aboriginal women specifically caused resentment among other prisoners and custodial staff, who feel that all women should receive equal support. This highlights the historical neglect of adequate care for all women, and that the great demand for a range of additional support services clearly outstrips supply. The compounding gender and social inequality experienced by Aboriginal women also points to the need for effective anti-racism strategies in staff training and prison programs.

There are still many gaps in release planning, with lack of responsibility taken by any of the government departments involved in the life of an Aboriginal woman in prison. It was strongly advised that CSNSW *do some of that groundwork before they actually go and not just let them go... [and] they need to have that sort of system in place that actually looks at, you know, effective pathways for those people that are coming out of prison* (Dea). Special attention is urgently required for strategies to return women to their regional and remote communities if they require, but who have been released into an urban area such as Western Sydney instead. For all Aboriginal women to be properly supported will require coordinated linkages to service providers in other regions of the state.

Early on, the AMSWS identified securing permanent housing as almost a prerequisite for meaningful relationship building with the women themselves: *"Our experience is that it is the biggest enabler to women's participation in the program, but extremely scarce"* (Leanne). This critical issue, although viewed as 'outside' the health sector, needs to be addressed urgently. As well as an increase in availability of housing stock, Aboriginal women exiting custody require *support to maintain living in the house, too. Keeping the rent and bills and the – keeping all the wheels turning on that* (Leanne). Failure to do so has a compounding effect on Aboriginal women and their families:



If the court systems need to see that the parent or the woman back in stable accommodation with support services, if there is any chance of restoration with children (Leanne).

Again, intersectoral relationships between Commonwealth and State Government Departments are crucial here. In interview, the need for greater accountability of governments was raised several times. In addition to accountability translating their policies into programs and interventions, AMSWS staff asserted the need for *KPIs at another level, which is what the outcomes are for the clients of the service* (Dea). Aboriginal women's ability to access housing, family support and health (including mental health) and other services is key to their successful community life after release from prison (SPRINT Project Team, 2013).

At the community level

Accountability and performance indicators were discussed in the interviews in some detail – about the range of appropriate outcome measure for clients, how to measure these, and how to measure progress made toward reaching goals, as part of outcomes. Particularly discussed was how to evaluate wholistic care, and:

That whole spider effect. That interconnected – you know, then the chronic care team are saying she's becoming really well. Old Mrs Smith's getting better. I wonder what's going on? Because the grandies aren't driving her crazy. They're back with mum. You know. Then the childcare family doing assessments on the little kids. The school retention stuff. That whole interconnected community. (Leanne).

Culturally-appropriate services that operate from a community base and incorporate known critical effectiveness factors for improving social and emotional wellbeing of individuals, families and communities (e.g., Haswell et al., 2013) are more likely to be effective in the long-term. Culturally appropriate services are considered in a recent NACCHO Submission to the *Towards a National Primary Health Care Strategy: Fulfilling Aboriginal Peoples Aspirations to Close the Gap* (February 2009) which states:

The primary health care delivered by Aboriginal community-controlled health services is culturally appropriate because they are: 'An incorporated Aboriginal organisations, initiated by a local Aboriginal community, based in a local Aboriginal community, governed by an Aboriginal body which is elected by the local Aboriginal community, delivering a holistic and culturally appropriate health service to the community which controls it'.

At the organisational level

In establishing pilot programs such as Returning Home, which is targeted support opportunity for Aboriginal women exiting custody, it is essential to first establish a shared vision between stakeholders to guide and underpin program



implementation. Leadership by funding bodies is essential in this, to establish pathways and remove obstacles for sharing information required to address the multiple disadvantages Aboriginal women exiting prison face.

The pilot's focus on primary health care outcomes, including chronic conditions and mental health, presented a challenge in terms of fitting in with pre-established pathways for referrals and care between local services, as well as within AMSWS, as did the divisions between Commonwealth and State, and Health and Corrections.

Obtaining referrals was an early challenge which was successfully addressed through the Returning Home promotional materials distributed through the networks in CSNSW and Justice Health & Forensic Mental Health Network, to be passed to women prisoners who may wish to be involved. Gaps persist in the needs women have, the complexity of them, the availability of services, and the capacity for services to respond:

There's no support services who will take on someone without a house that they can go to, to implement the changes. You ring up for any dimension, acute mental health team, "Where are they living?" "They're homeless." "Where do they live?" "Nowhere." "Well then where are we going to go to pick them up?" (Leanne).

At the system level

The Western Sydney Returning Home pilot provides several lessons for initiatives to support Aboriginal women going back to the community from custodial care. Overall, they point to the urgent need to address the gaps in communication and understanding between Commonwealth and State Departments of Health and Corrections, and the silos that occur within organisations, if a wholistic throughcare service model incorporating an integrated case management approach is to become the norm.

The AMSWS faced significant challenges throughout the project that they had hoped would provide them with an opportunity to build on their previous work with SPRINT. However, Commonwealth funding for the national project was rolled out through Medicare Locals. The WSML, recognising the AMSWS's strengths and expertise in this area, subcontracted them to develop and deliver Returning Home in Western Sydney. While pleased at the outcome from an Aboriginal primary health care perspective, AMSWS was disappointed with the process: *"But we wish it was not done this way. [The funding] should have gone to the AMSWS and not Medicare Locals."* This enables Aboriginal leadership in issues that affect the Aboriginal community, and harnessing energy and processes from the successes seen in NACCHO's member services and other



Aboriginal medical services (Panaretto, Wenitong, Button and Ring, 2014); this is urgent cross-fertilisation in light of the gross over-representation of Aboriginal and Torres Strait Islander people in the criminal justice system, and the continued worsening of this despite policies committing to redressing it.

Continuity of funding is a major obstacle to achieving and sustaining outcomes in the community, especially for vulnerable groups. The AMSWS has a long-standing commitment to working with those in the criminal justice system, including experience with a transitional program at Dillwynia Correctional Centre: *"It worked so beautifully, I'm not sure why they didn't keep it funded"* (Leanne). Pilot projects or seed funding should include provision for extension if the early work shows promise. As demonstrated here, it can be difficult to retain and recruit staff with the necessary skills and attributes on a short-term contract.

Within-government collaboration and communication reforms were also recommended by AMSWS staff involved in Back to Community. This related to the compounding difficulties they experienced in negotiating three different prisons, as well as CSNSW and the JH&FMHN, which also have very different cultures and processes:

As experienced, when you sit in a health setting, and then you've got to sit in corrections and have a meeting there, the atmosphere and the culture – completely different (Dea).

Each of the three correctional centres AMSWS was to work with had its own administration, culture and processes. This effectively tripled the time required for liaison and relationship building. Other RHCCC pilot projects had one correctional facility to work with. AMSWS received conflicting information about how to go about applying for access as Professional Visitors, and having this approved:

So it's almost as though there's changing rules all the time about how you need to engage with them. Then being an AMS or an Aboriginal outreach working within the context of the health system, within the context of the prison system – three different pathways (Leanne).

Again, given access to the correctional centers was stalled, the AMSWS were restricted in their capacity to meet the women prior to their release and provide throughcare. Service integration requires supportive structures in place at all levels of all organisations involved.

This extends to overcoming organisational and system barriers to ensure the inclusion of other parts of the justice system in pilots such as this. AMSWS staff acknowledged the potential role of Back to Community Care Coordinators



positively influencing sentencing, by enhancing mutual understanding of the process itself to the woman and the circumstances of the woman to the magistrate. Additional benefits of involvement at pre-sentencing were being an advocate for the women, and to help initiate the relationship once inside. AMSWS staff found that court sentencing dates and outcomes proved unpredictable, limiting referrals from that source, and placing some Aboriginal women in great vulnerability, without support plans in place if released from court to community.

Further, the parole period was identified by AMSWS staff as a significant opportunity for working collaboratively to improve ex-prisoners' social and emotional wellbeing. Involvement of Probation and Parole in pilots such as this is crucial, as is reviewing and refining the role of Probation and Parole to ensure it is a supportive mechanism, beyond surveillance (Brown and Bloom, 2009; Jones, Hua, Donnelly, McHutchinson and Heggie, 2006; Schram, Koons-Witt, Williams and McShane, 2006). Very briefly here, greater options for drug and alcohol rehabilitation were also advocated for, as options instead of sentencing to prison, and as options after release from prison.

Improving governments' accountability for meeting their policy responsibilities was also a key concern of AMSWS staff involved with Back to Community, both in health and in criminal justice domains. As well as the mismatch between what policy states it will achieve to support Aboriginal and Torres Strait Islander people in the criminal justice system, compared to the poor outcomes experienced, accountability mechanisms were viewed as inappropriately vague, ill-defined and unavailable. Greater accountability was advocated in the form of meeting outcomes set and agreed by key stakeholders. They discussed how key performance indicators should be to be attached to high-level positions in government: *You've got to embed it in their contracts, otherwise it's – if you embed it further down here, well, whose responsibility is it, you know?* (Dea).

Given the underlying multiple public health and underlying social risk factors for incarceration, and upstream social determinants of health that need to be addressed (Royal Commission into Aboriginal Deaths in Custody, 1991; Davis & Brands, 2008), the AMSWS staff also advocated for greater accountability for the criminal justice system in wholistic, preventative care: *The person who's at the helm needs to have specific measures based, you know, in their performance contracts. What are you doing in respect to improving education or health or prison outcomes?* (Dea). Further, more effective expenditure of allocated funds was considered urgent. Justice Reinvestment was identified as one potential strategy to investigate further, for its utility reorienting expenditure in the criminal justice system to intersectoral collaboration, community strengthening and crime prevention initiatives.



Conclusion

The evaluation team commends the AMSWS for its long-standing commitment to improving health and social outcomes for Aboriginal people who come into contact with the criminal justice system. They demonstrated capacity to build on their experience supporting Aboriginal and Torres Strait Islander people in the criminal justice system as well as involvement in the SPRINT study. Using an eco-social, wholistic Aboriginal health lens, this formative evaluation shows how many of the organisational supports were in place for their culturally-sensitive, wholistic model of care, including recruitment of an experienced care coordinator. At the individual level, for Aboriginal women, the AMSWS provided comprehensive primary health care, and had many linkages to other sources of support, extending to support for family and connection to community activities as appropriate. The pre- and post- assessment tool and engagement with 12 Aboriginal women helped refine and demonstrate the emerging model of care. However this was stalled by lack access to the three prisons in the area and therefore, opportunities to connect with women pre-prison release. Establishment of a referral system still generated some connections. Several contextual issues compounded at the structural level, including the nature of the time-limited pilot funding and loss of the staff member to other permanent employment, inadequate time to recruit and re-commence the process for correctional centre approval and multiple relationships to negotiate to gain this between CSNSW and JH&FMHN. This somewhat reflects, too, the complex support requirements for Aboriginal women being released from correctional centres experience, who often have a multiplicity of health and social issues intertwined with child removal, poverty, poor education and employment histories, trauma and alcohol and drug misuse, which all in turn present as risks for incarceration, and re-incarceration. Concerted, consolidated, high-level leadership, planning and accountability is clearly required to ensure effective mechanisms for embedding projects such as these across multiple sectors and levels of government, and to ensure barriers are removed in the process, for specialist community-based organisations such as AMSWS to in-turn implement their culturally-informed models of care.



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Appendices


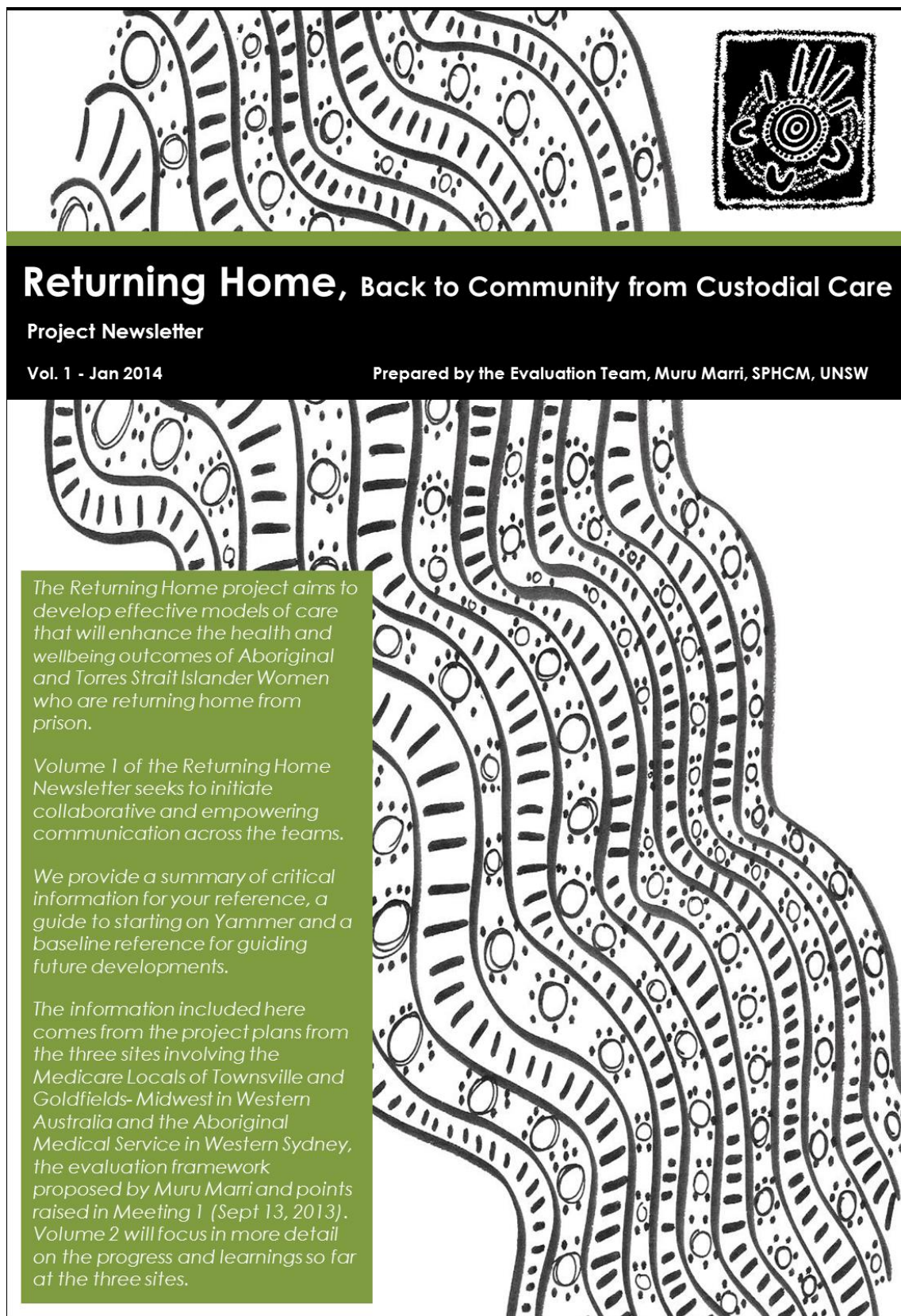
Appendix 1: List of people consulted

- Aboriginal Medical Service Western Sydney
 - Dea Delaney Thiele
Head of Population Health Research Unit
 - Leanne Schuster
Manager of Social and Emotional Wellbeing Team
 - Sheilah Hure,
Team Leader of Health Promotion, Public Health Officer
- Corrective Services NSW
 - Deirdre Hyslop
Principal Advisor for Women in Custody
 - Vivien Scott
Regional Aboriginal Project Officer
 - David McConnell
Secretary of Corrective Services NSW Ethics Committee.

Appendix 2: Interview guide

Introduction	<ul style="list-style-type: none"> • Muru Marri, who we are and what we do • Your organisation/service and your role <ul style="list-style-type: none"> - What does your organisation/service do? - How does your organisation/service contribute with women returning home from prison? What is your role?
Returning Home project	<ul style="list-style-type: none"> • What outcomes would you like to see for women returning home from prison? Can you describe your ideal scenario? • What is your understanding about the Returning Home project? • What is your role with Returning Home? • What do you hope for Returning Home to achieve in your area? • What have been your experiences with Returning Home so far? • What have been the main achievements and challenges? • What are your expectations for the next few months?
Other matters	<ul style="list-style-type: none"> • Other items of interest • Next steps, thanks and closing.





Returning Home, Back to Community from Custodial Care

Project Newsletter

Vol. 1 - Jan 2014

Prepared by the Evaluation Team, Muru Marri, SPHCM, UNSW

The Returning Home project aims to develop effective models of care that will enhance the health and wellbeing outcomes of Aboriginal and Torres Strait Islander Women who are returning home from prison.

Volume 1 of the Returning Home Newsletter seeks to initiate collaborative and empowering communication across the teams.

We provide a summary of critical information for your reference, a guide to starting on Yammer and a baseline reference for guiding future developments.

The information included here comes from the project plans from the three sites involving the Medicare Locals of Townsville and Goldfields- Midwest in Western Australia and the Aboriginal Medical Service in Western Sydney, the evaluation framework proposed by Muru Marri and points raised in Meeting 1 (Sept 13, 2013). Volume 2 will focus in more detail on the progress and learnings so far at the three sites.



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Returning
Home Project
Newsletter

Returning Home

Back to Community from Custodial Care

Introduction

The Returning Home project is starting its final trimester with significant progress made on the ground by each of the sites and a wealth of material collected for the evaluation.

The second edition of this newsletter seeks to inform, empower and encourage those working hard towards the Returning Home aims, providing a glimpse into the developments made across different aspects of the project and a taste of the insights obtained so far.

With the aim of keeping the information in this newsletter short and digestible, we do not hope to be exhaustive and will solely introduce what we think are the most useful updates and insights to the completion of the project.



this issue

Visits from evaluation team **P. 3 & 5**

Tools and resources **P. 2, 4, 7 & 8**

Team **P. 6**

Connections established **P. 6 & 7**

Essential components of Throughcare - SPRINT

SPRINT is the study, led by AMSWS and UNSW researchers, that the Returning Home project emerged from. Its aim was to develop culturally specific understandings of how primary health care services can better meet the health care and social support coordination needs of Aboriginal Australians transitioning from the criminal justice system into the community, with a view to reducing reincarceration and improving quality of life.

The Policy Options briefing paper for SPRINT's literature review provides a snapshot to the key findings from the systematic literature review and a clear definition of how throughcare and how it should be done to be effective.

Further information in the link below:
http://files.aphcri.anu.edu.au/research/loyd_-_systematic_review_-_policy_options.pdf

SPRINT Policy Options (excerpt)

THROUGH-CARE

Whilst throughcare is corrective services' official policy, in practice, programs are not continuous, coordinated or evaluated. There is a lack of awareness of potentially suitable programs amongst Aboriginal people who are in custody or who are recently released. Similarly, community based service providers are not fully aware of the range of programs available. There is lack of communication between prisons, government agencies and community service providers, which further decreases access and effectiveness for Aboriginal prisoners.

(Excerpt from The effectiveness of primary health care and social support services in meeting the needs of Aboriginal people released from the criminal justice system: a systematic literature review, Policy Options, June 2013.)

Continues on page 4

Prepared by the Evaluation Team, Muru Marri, SPHCM, UNSW, on behalf of and in collaboration with the Returning Home team. The opinions expressed in this publication are those of the authors and not necessarily those of the programs